Early Intervention State Performance Plan
Monitoring Priorities and Indicators
Rhode Island Department of Human Services

Submitted by:

Brenda DuHamel, Part C Coordinator

Resubmitted February 2009 to include additional information on Indicators #3 and revised improvement plans

UNITED STATES DEPARTMENT OF EDUCATION
OFFICE OF SPECIAL EDUCATION PROGRAMS
Washington, DC 20202-2600

Overview of State Performance Plan Development;

DHS' process used to develop the SPP included (1) broad stakeholder input and (2) dissemination of the SPP to the public.

1. The following letter was sent on August 30th, 2005:

Hello everyone,

The Department of Human Services, as the lead agency for Early Intervention in Rhode Island, is organizing a workgroup to develop the new State Performance Plan for the Office of Special Education Programs (OSEP), which is due on December 2, 2005 and will be the focus of our improvement activities over the next six years. We would like to invite you to participate on this workgroup, which will look at baseline data for each of the required indicators and develop "measurable and rigorous targets" for improvement during these six years. The group will also identify possible improvement activities in order to meet these targets.

Several of you have been involved in the child outcomes workgroup. This workgroup was simply expanded upon and will be rolled into the State Performance Plan workgroup. Please continue to complete the research agreed upon and bring it to the meeting scheduled for September 13th. I have attached a list of the meeting schedule and agenda as an attachment and a list of the specific indicators as another attachment. Due to our timelines, it is crucial that we meet weekly in order to address each of the 14 indicators required. If you cannot attend the majority of the meetings, you may wish to designate someone else. We realize that this is a big time commitment. We will work to provide as much information as possible prior to each meeting so that members can be prepared and can provide input via email if they cannot attend one of the meetings.

We look forward to this collaborative effort in developing a "plan for progress" for Rhode Island's Early Intervention Program. Please respond regarding your ability to participate by September 2nd.

Thank You.

State Performance Plan Workgroup members:

Brenda DuHamel, DHS
Jennifer May, DHS/ACS
Robin Etchingham, DHS/ACS
Christine Robin, DHS
Ellen Jacobs, EI certified provider
Sharon Terreault, EI certified provider
Maureen Whelan, Transition Coordinator
Lisa Schaffran, Rhode Island Parent Information Network, parent
Ester Brito, Rhode Island Parent Information Network, parent
Dawn Wardyga, ICC chairperson, Family Voices, parent
Deborah Milton, Rhode Island Parent Information Network, parent
Kim Teves, ICC member, parent

Meetings and agenda:

Thursday, September 8th, 2005	9:30 – 11:30 am	Hasbro	Indicators 1 & 2
Tuesday, September 13th, 2005	1 – 3 pm	RIPIN	Indicator 3
Tuesday, September 20th, 2005	10 am – 12 noon	Sullivan	Indicators 4 & 5
Wednesday, September 28th, 2005	12 – 2 pm	Associates	Indicators 6 & 7
Tuesday, October 4th, 2005	10 am – 12 noon	Annex	Indicator 8
Wednesday, October 12th, 2005	10 am – 12 noon	Sullivan	Indicators 9 -13

Tuesday, October 18th, 2005	10 am – 12 noon	Sullivan	Indicator 14
Monday, November 14th, 2005	10 am – 12 noon	Directors	Wrap-up

2. Additionally, the annual ICC retreat held November 16, 2005 was utilized to obtain additional stakeholder input as well as disseminate to the public. The agenda included:

Interagency Coordinating Council/Early Intervention System
2005 Retreat
Agenda
Thursday, November 17, 2005
Alton Jones Whispering Pines Conference Center
West Greenwich, RI

8:45 am - 3:30 pm

8:45 am Registration/Continental Breakfast

9:00 am Welcome/Introductions/Icebreaker(s)

9:30 am Panel – IDEA 2004 (General, Natural Environments, SPP)
NECTAC: Evelyn Shaw
OSEP: Ginger Johnson

10:30 am Break

10:45 am Panel – Questions & Discussion

12:00 pm Lunch

12:45 pm RI SPP Draft – Overview and Group Activity Instructions: B. DuHamel

1:15 pm SPP Group Activity
General Review
Focus on Improvement Activities/Timelines/Resources

2:15 pm Break

2:30 pm SPP Group Activity (continued)

3:15 pm Wrap-up/Next steps

3:30 PM Adjourn

Participants	Agency
Akers, Cindy	Groden Center for Autism
Antosh, Anthony	Rhode Island College
Baker, Lee	Department of Children, Youth and Families
Beaton, Diana	Department of Human Services
Brito, Ester	Rhode Island Parent Information Network
Buontempo, Susan	DHS
Conley, Catherine	Parent
Cross, Kathleen	James L. Maher Center
Deboise, Teri	Children's Friend & Service
DiMauro, Lissa	DHS
DiPalma, Linda	Family Service RI
DuHamel, Brenda	DHS
Etchingham, Robin	DHS
Florio, Deb	DHS
Garneau, Deb	Department Of Health
Grattan, Amy	Rhode Island Department of Education
Harris, Jill	OSEP
Harris, Laura	Parent
Horm, Diane	University of Rhode Island
Horridge, Stephanie	Department of MHRH
Huges, Linda	RI Services for the Blind & Visually Impaired
Iovino, Janet	Parent
Jacobs, Ellen	Hasbro

Johnson, Ginger	OSEP
Landry, Lisa	Parent
Lessing, Ben	Family Resources Comm. Action
MaGaw, Darlene	Family Resources Comm. Action
Mageria, Cresentia	Parent
Marquez, Janet	CEDARR
May, Jeni	DHS
McMullen, Linda	Parent
Mickey, Michelle	DHS
Milton, Deborah	RIPIN
Nugent, Mary	Head Start
Robin, Christine	DHS
Schaffran, Jerry	University of RI-Training Center
Schaffran, Lisa	RIPIN
Schiaroli, Barbara	James L. Maher Center
Shaw, Evelyn	NECTAC
Taylor, Maura	Hasbro
Terreault, Sharon	Meeting Street
Terzian, Sharon	RISEAC Liason
Teves, Kim	Parent
Vandal, Susan	RIPIN
VanDeusen, Ernie	Trudeau
Wardyga, Dawn	RIPIN
Weidenman, Leslie	Groden Center

Whelan, Maureen	Rhode Island of College
Williams, Iraida	Parent
Williams, Susanne	Pawtucket School Department
Yatchmink, Yvette	Lifespan-Child Development Center
Young, John	DHS

A draft of the State Performance Plan was disseminated at the ICC retreat and a final copy will be disseminated to this committee at the next meeting scheduled for February 24, 2006. The Department of Human Services has additional plans in place to disseminate the State Performance Plan to the public. Once approved by the Secretary, the State Performance Plan will be included on the official Department of Human Services website for public viewing and a postcard will be sent to all stakeholders including the Leadership Roundtable for Children with Special Health Care Needs notifying them of the addition to the website.

Monitoring Priority #1:

Early Intervention Services In Natural Environments

Indicator:

1. Percent of infants and toddlers with IFSPs who receive the Early Intervention services on their IFSPs in a timely manner.

(20 USC 1416(a)(3)(A) and 1442)

Measurement:

Percent = # of infants and toddlers with IFSPs who receive the Early Intervention services on their IFSPs in a timely manner divided by the total # of infants and toddlers with IFSPs times 100.

Account for untimely receipt of services.

Overview of Issue/Description of System or Process:

The foundation of EI is the collaboration between families and professionals, using a family-centered approach. EI strives to provide comprehensive, community-based, culturally sensitive services designed to meet the developmental challenges of eligible children and families. Families, together with EI professionals, determine the desired outcomes for their child, the strategies for accomplishing these outcomes and the supports needed by the family. These goals, and the services needed to support obtaining these goals, are written in an Individualized Family Service Plan (IFSP).

The delivery of services to a child who is eligible is a joint process in which family members are full partners; thus the education of family members is a primary goal of all EI activities. Certified EI providers coordinate this process. To the maximum extent possible, services are provided in home and community locations so that naturally occurring learning opportunities may be maximized.

The RI Department of Human Services (DHS) has made a commitment to the following goals:

- All eligible infants and toddlers are identified, evaluated/assessed and enrolled, with particular attention to reaching those with the highest needs.
- Services are tailored to optimize each individual child's potential, and to address family needs. Services are offered in a variety of natural environments and in an inclusive manner.
- All participating children have a successful transition to appropriate systems and services when they are discharged.
- Available funds (public and private) are leveraged and services are coordinated to better serve more infants and toddlers with developmental delays and disabilities.

- Based on Individualized Family Service Plans (IFSPs), appropriate and accessible providers are available for the array of interventions needed by EI infants, toddlers, and their families.

Timely quality services are important to the families we serve and to DHS. In the past, timeliness of services was monitored through family surveys. DHS will now be utilizing the data system to monitor timeliness. Since a review of the data to determine timeliness of services, it was found that providers have been entering the initiation date of services as the same for all services when the IFSP begins, even if, for example, a group is only scheduled to start in six weeks. DHS recognizes that training in this area is needed. Another factor that impacts timely services is family cancellations and no shows for appointments.

Baseline Data:

65.73% of infants and toddlers with IFSPs receive the Early Intervention services on their IFSPs in a timely manner.

Services Given Timely	IFSPs	Percentage
Yes	6104	65.73%
No *	3183	34.27%
	9287	

*Between July 1, 2004 and June 30, 2005 there was a no-show/cancellation rate of **10.28%.**

Discussion of Baseline Data:

6104/9297 x100= 65.73%

OSEP REQUIRED DEFINITION CHANGE

Timely Services Technical Documentation

Definitions
a) Timely Services - All services must begin within 30 days of the initial, annual or review of any IFSP (IFSP Review date).
b) Timely Services Percent - # of services infants and toddlers with IFSPs receive in a timely manner divided by the total # of services infants and toddlers with IFSPs receive times 100 (OSEP).
c) Enrolled - The child's first IFSP (with a federal service) start date is before the reporting time period and the child has not been discharged before the start date of the reporting time period.

Time Period- Time period selected for review limits both the IFSP time frame and the services rendered time frame. Services on the IFSP will only be counted if the intended date for delivery is also in the time period being reviewed (if review time period is 1/04-12/04 and the start date of services is 12/1/04, these services are not counted because the intended start falls outside the time period reviewed 1/15/05).

1. Counted IFSP Services - all services on the initial/annual or review IFSP where the initial/annual or review date falls between the time period in review. Each type of service will only be counted once taking the first review date when the service began.

2. Count delivered services that fall within the time frame being reviewed.

3. If intended date is not between the time period being reviewed - service is not counted

4. IFSP table is linked with services delivery table by child and service. Services given between the IFSP review date and intended date are marked as timely. (Any service given less than once a month is given a 6 month intended date)

5. All remaining services (not marked timely or not within time frame) are marked as untimely

6. Justification for untimely services will be added to the new system and will be considered compliant in our reporting to OSEP.

Measurable and Rigorous Target(s)

2006 Target: 100% services received in a timely manner
2007 Target: 100% services received in a timely manner
2008 Target: 100% services received in a timely manner
2009 Target: 100% services received in a timely manner
2010 Target 100% services received in a timely manner
2011 Target 100% services received in a timely manner

Improvement Activities/Timelines/Resources

1. In 2005, the EI program was transitioned to a new lead agency, the Rhode Island Department of Human Services (DHS). As a result, the state has instituted a programmatic improvement process beginning with the revision of the EI provider Certification Standards. Presently, DHS staff is reviewing applications for current and new providers. Certifying additional providers on a rolling basis will enable the state to maximize its capacity to serve eligible infants and toddlers. For current providers revised standards will take effect January 1, 2006. This redesign addresses compliance issues related to numerous components of the EI program. Additionally, State Rules and Regulations were revised, internal policies and procedures were rewritten and contractual agreements will be put in place to help address past noncompliance.

Specifically, Rhode Island will award and utilize a new contract to improve the state's comprehensive system of personnel development beginning February 1, 2006. Products to be delivered under the contract include development of new curricula and materials for both pre- and in-service training, technical assistance in the provision of services for low-incidence populations, and the development of recruitment and retention strategies for qualified personnel. Activities will include:

- Development of work plan to implement strategies and activities addressing capacity and workforce issues. An annual plan of strategies and activities must be submitted for prior approval by DHS. Particular emphasis must be placed on the recruitment and retention of early care and education service providers, including qualified personnel for EI as well as direct service staff for other programs for CSHCN.

- Collaboration with regional colleges and universities to promote opportunities for pre-service exposure to CSHCN programs, including presentation to potential students and interns. Contractor will also collaborate with DHS certified providers to better identify in-service training needs for qualified staff. Documentation of these collaboration efforts must be recorded and included in the semi-annual progress report to DHS, along with any approved strategies/activities during that period.

- Placement of at least one college intern student in at least two certified EI programs and two additional students in two other CSHCN provider sites by year two of contract. In the third year of the contract, a total of six college intern students will be placed in EI certified programs and/or other CSHCN provider sites. Contractor will coordinate the placements with certified EI providers in order to allow for most appropriate supervision.

- Coordination and provision of a seminar for all clinical supervisors in EI to be held quarterly. It is required that all staff providing clinical supervision attend at least 8 hours per year of training in this area. Seminars must include, at a minimum, training and discussion related to:

  - Supervisory skill-building
  - Quality Improvement
  - Ethical and Risk Management Issues
  - Collaborative problem-solving

- In order to promote personnel development, DHS offers EI staff a fixed rate of reimbursement for loss of work due to professional development and training. Contractor will utilize DHS's Early Intervention system to approve, track, and submit the training request invoices for payment to DHS's fiscal unit for all certified EI providers. Contractor will provide a report to DHS quarterly including detailed information on each EI provider's personnel professional development and training requests and reimbursements.

Additionally, revised certification standards mandate providers to contract with other agencies or professionals as needed to assure families have access to all services as identified on their IFSP.

2. Effective January 1, 2005, legislation mandated that private insurance carriers licensed in Rhode Island covering children in Early Intervention, must reimbursement providers for the first $5000 of Early Intervention services per calendar year per insured child. As a result, providers must now utilize two sets of reimbursement codes; those used prior to the mandate (local codes) and national codes, which are employed by insurance carriers.

In the writing of the State Performance Plan, it became evident to DHS that this reimbursement structure has created discrepancy in how services are labeled and recorded in the data system, potentially effecting data collection results, but <u>not</u> the

provision of actual EI services. For example, a social work service entered in the IFSP might be billed as special instruction on the Services Rendered Form (SRF). DHS is developing a reimbursement manual as a technical resource guide for providers. All providers will receive training regarding appropriate data entry. This will ensure congruency between services identified on the IFSP and what is recorded in the data system. This manual will be made available to all providers by January 1, 2006.

These improvement strategies were designed in response to the letter received from OSEP on October 4th, 2005 based on RI's submission of its Federal Fiscal Year 2003 Annual Performance Report (APR).

Revised/new improvement activities as of 2/1/08:

Improvement Activities	**Timelines**	**Resources**
Develop a reimbursement manual	June 08-timeline revised to coincide with paperwork revision project.	Lead agency staff, providers, Sherlock Center on Disabilities
Revise EI paperwork in order to match services identified on IFSP with services documented on services rendered forms. Reimbursement guide will be completed, but is no longer the mechanism for improved compliance in this area; instead this was done through the paperwork revisions.	Pilot by 12/07 Implement by 3/08	Paperwork Project Committee (Lead agency staff, Sherlock Center on Disabilities, providers)
Monitor reliability and accuracy of timely services data report.	6/08 and ongoing	Data manager, providers

Revised/new improvement activities as of 12/08:

Improvement Activities	Timelines	Resources
New activity: Analyze and decide whether or not to change timely service definition to date of initiation as agreed to by the parent signature on the IFSP in order to simplify and improve reliability of monitoring reports.	Make final decision by 3/31/09 and implement by 5/1/09	Data manager, providers, ICC, lead agency staff, Sherlock Center on Disabilities
New activity: In order to address the difficulties that providers face in recruitment and retention of therapists, the State will begin collaboration with higher education personnel to (1) develop consistent procedures for student placements/internships in EI (2) convene a high interest training annually for EI and other early childhood staff (3) develop and present on career choices in EI to a variety of college and community venues	By 1/09 and ongoing	Sherlock Center on Disabilities and the University of RI.

Monitoring Priority: #2

Early Intervention Services In Natural Environments

Indicator:

2. Percent of infants and toddlers with IFSPs who primarily receive Early Intervention services in the home or programs for typically developing children.[1]

(20 USC 1416(a)(3)(A) and 1442)

Measurement:

Percent = # of infants and toddlers with IFSPs who primarily receive Early Intervention services in the home or programs for typically developing children divided by the total # of infants and toddlers with IFSPs times 100.

Data Source: Data collected for reporting under section 618 (Annual Report of Children Served).

Overview of Issue/Description of System or Process:

Eligible children and families must have equal access to comprehensive EI services, regardless of geographic location. EI services must be made available to all eligible children, regardless of gender, race, ethnicity, religious beliefs, cultural orientation, economic and educational status, medical diagnosis or disabling condition.

Each EI provider must utilize evaluation and assessment procedures that are responsive to the unique demographic, cultural, racial, and ethnic characteristics of families served. EI staff and parent consultants adopt, adjust, and monitor best family centered practice in an ongoing process to improve the quality of the EI system.

Additionally, EI services, to the maximum extent appropriate and as determined by the IFSP team, must be provided in natural environments, including the home and community settings in which children without disabilities participate. This also means settings that are natural or normal for the child's age peers who have no disability. Services are delivered elsewhere only when early intervention cannot be achieved satisfactorily for the infant or toddler in a natural environment and a justification statement must be included.

Natural environments are the day-to-day settings, routines, and activities that young children learn best in. Parents are involved in helping their children learn. Family members and caregivers can do the actual "hands-on" throughout the day as opportunities arise, with the service providers acting as consultants, teachers, and coaches.

[1] At the time of the release of this package, revised forms for collection of 618 State reported data had not yet been approved. Indicators will be revised as needed to align with language in the 2005-2006 State reported data collections.

Baseline Data:

94.49% of infants and toddlers with IFSPs primarily receive Early Intervention services in the home or programs for typically developing children.

Discussion of Baseline Data:

1219 /1290 x100=94.49 %

TOTAL (ROWS 1-7)	1290
1. PROGRAM DESIGNED FOR CHILDREN WITH DEVELOPMENTAL DELAY OR DISABILITIES	71
2. PROGRAM DESIGNED FOR TYPICALLY DEVELOPING CHILDREN	182
3. HOME	1031
4. HOSPITAL (INPATIENT)	1
5. RESIDENTIAL FACILITY	0
6. SERVICE PROVIDER LOCATION	0
7. OTHER SETTING*	5

* Please list the Other Settings included:	Daycare, play groups, Library, Pool, School Department, Professional office buildings and other similar environments

This data is currently collected in the Early Intervention Management Information System (EIMIS). Providers enter all services for each child in the EIMIS. For this report a query is run to find the active IFSP for each child that served at the point in time, December 1, 2004.

1. For each Early Intervention service setting, the number of infants, toddlers, or families receiving services according to IFSP on December 1, 2004 was recorded.
2. The count is unduplicated (i.e., each infant and toddler is represented only once in the table).
3. Determination of primary setting is based on the IFSP in place on December 1, 2004. For example, if the IFSP says that the child will receive 1 hour of physical therapy services in their home each week, then the home is the primary setting.
4. If a child is receiving services in more than one setting, the child is counted in the setting in which he or she receives the most hours of Early Intervention service, *i.e., the primary setting*. For example, a toddler who receives 1 hour of home-based service a month and 4 hours of service per month in a clinic (a service provider location) would be counted under the category "service provider location."

Measurable and Rigorous Target(s):

2006 Target: 95% of services primarily received in the natural environment
2007 Target: 95% of services primarily received in the natural environment
2008 Target: 95% of services primarily received in the natural environment
2009 Target: 96% of services primarily received in the natural environment
2010 Target 96% of services primarily received in the natural environment
2011 Target 96% of services primarily received in the natural environment

Improvement Activities/Timelines/Resources

1. All EI staff within six (6) months of employment must participate in Introduction to Early Intervention training program. This curriculum is currently being revised and will be implemented in April 2006. The curricula will include clarity on the definition of natural environments and the importance of providing services to infants and toddlers in the contexts of their everyday routines. Training will include identifying appropriate justifications for services not provided primarily in the natural environment and the importance of entry of this information into the EIMIS. Course will be offered twice annually and must include, at a minimum, training in the following areas:

- Overview of IDEA
- Family-centered practice
- Eligibility for community based services and supports
- Evaluation and assessment
- Natural environments/natural learning opportunities
- Development of the IFSP, including the development of functional and measurable outcomes
- Transition from Early Intervention
- Coordinating with system-wide resources for infants and toddlers and their families, including Medicaid (RIte Care and Fee-For-Service), CEDARR Family Centers (CFC), CEDARR Direct Services, Head Start, Child Care and other DHS administered services, along with various community services and supports.
- Procedural safeguards which include the following areas: (1) Family Rights and Responsibilities, (2) Confidentiality and Notices, (3) Access and Location of Information, and (4) Violation Safeguards.

2. As part of the lead agency's new monitoring system, beginning January 2006, data based on performance standards in Certification Standards will be analyzed monthly on provision of services primarily in the natural environment to determine trends and develop strategies for improvement.

The Natural Environment performance standards requires that the EI provider must deliver the majority of services, to the maximum extent appropriate and as determined by the IFSP team, in natural environments, including home and community settings in which children without disabilities participate. For each service listed in the IFSP that is not delivered in a natural environment the majority of the time, a justification statement is

required on the IFSP and in the EI data system. The majority is defined as greater than 50% of EI services. Failure to deliver less than 80% of all IFSP services in natural environments may result in provisional certification status and associated reimbursement schedule changes.

3. Public awareness activities targeting pediatricians and family practice physicians will be coordinated through our public awareness committee. These activities will improve their understanding of the Early Intervention service delivery model in order to deliver a more congruent message to families, pediatricians and other service providers regarding how Early Intervention services are delivered.

These improvement strategies were designed in response to the letter received from OSEP on October 4th, 2005 based on RI's submission of its Federal Fiscal Year 2003 Annual Performance Report (APR).

Revised/new improvement activities as of 2/1/08:

Improvement Activities	Timelines	Resources
Develop a reimbursement manual	June 08-timeline revised to coincide with paperwork revision project.	Lead agency staff, providers, Sherlock Center on Disabilities
Revise EI paperwork in order to match services identified on IFSP with services documented on services rendered forms. Reimbursement guide will be completed, but is no longer the mechanism for improved compliance in this area; instead this was done through the paperwork revisions.	Pilot by 12/07 Implement by 3/08	Paperwork Project Committee (Lead agency staff, Sherlock Center on Disabilities, providers)
Monitor reliability and accuracy of timely services data report.	6/08 and ongoing	Data manager, providers

Monitoring Priority:

Early Intervention Services In Natural Environments

Indicator:

3. Percent of infants and toddlers with IFSPs who demonstrate improved:

    1. Positive social-emotional skills (including social relationships);

    2. Acquisition and use of knowledge and skills (including early language/ communication); and

    3. Use of appropriate behaviors to meet their needs.

(20 USC 1416(a)(3)(A) and 1442)

Measurement:

A. Positive social-emotional skills (including social relationships):

   a. Percent of infants and toddlers who reach or maintain functioning at a level comparable to same-aged peers = # of infants and toddlers who reach or maintain functioning at a level comparable to same-aged peers divided by # of infants and toddlers with IFSPs assessed times 100.
   b. Percent of infants and toddlers who improve functioning = # of infants and toddlers who improved functioning divided by # of infants and toddlers with IFSPs assessed times 100.
   c. Percent of infants and toddlers who did not improve functioning = # of infants and toddlers who did not improve functioning divided by # of infants and toddlers with IFSPs assessed times 100.

If children meet the criteria for a, report them in a. Do not include children reported in a in b or c. If a + b + c does not sum to 100%, explain the difference**.**

B. Acquisition and use of knowledge and skills (including early language/communication):

   a. Percent of infants and toddlers who reach or maintain functioning at a level comparable to same-aged peers = # of infants and toddlers who reach or maintain functioning at a level comparable to same-aged peers divided by # of infants and toddlers with IFSPs assessed times 100.
   b. Percent of infants and toddlers who improved functioning = # of infants and toddlers who improved functioning divided by # of infants and toddlers with IFSPs assessed times 100.

c. Percent of infants and toddlers who did not improve functioning = # of infants and toddlers who did not improve functioning divided by # of infants and toddlers with IFSPs assessed times 100.

If children meet the criteria for a, report them in a. Do not include children reported in a in b or c. If a + b + c does not sum to 100%, explain the difference**.**

C. Use of appropriate behaviors to meet their needs:

a. Percent of infants and toddlers who reach or maintain functioning at a level comparable to same-aged peers = # of infants and toddlers who reach or maintain functioning at a level comparable to same-aged peers divided by # of infants and toddlers with IFSPs assessed times 100.
b. Percent of infants and toddlers who improved functioning = # of infants and toddlers who improved functioning divided by # of infants and toddlers with IFSPs assessed times 100.
c. Percent of infants and toddlers who did not improve functioning = # of infants and toddlers who did not improve functioning divided by # of infants and toddlers with IFSPs assessed times 100.

If children meet the criteria for a, report them in a. Do not include children reported in a in b or c. If a + b + c does not sum to 100%, explain the difference**.**

Overview of Issue/Description of System or Process:

- In the Fall of 2005, all EI programs participated in a technical assistance meeting to receive training on the process of assessing child outcomes and reporting requirements.

- Each outcome area will be assessed by qualified professionals using a choice of measurement tools including curriculum based tools, standardized tools, parent report, observations, IFSP progress reviews, and professional evaluations. Through technical assistance the use of curriculum-based tools will be encouraged. This data will be collected, analyzed and reported on in the APR. RI does not have a required list of tools that must be utilized. Providers may utilize any of the above-mentioned tools that are appropriate to gather information about the child's functioning.

- Rhode Island has chosen to utilize the Early Childhood Outcomes (ECO) Center's Outcomes Rating Form to assign a simple rating of 1-7 for each area upon entry and exit of the Early Intervention program.

- All children exiting EI who have participated in the program for at least six (6) months will have a comparison between their entry and exit ratings to assess their level of progress.

- Assessment at entry will be completed during initial evaluation/assessment and assessment at exit will be completed at the annual evaluation/assessment

closest to their exit date. This exit rating will be reviewed during the child's transition process and will be changed if appropriate (i.e., notable improved functioning since the last annual evaluation/assessment).

- DHS will monitor and analyze data monthly.

All certified EI provider agencies were given the following procedure guidelines:

Rhode Island's Procedure for Measuring Child Outcomes

Per federal requirements, all children having an initial evaluation/assessment after January 1, 2006, must be assessed and given a rating score for each of the three child outcomes below:

Early Intervention Child Outcomes

- Children have positive social emotional skills, including positive social relationships.
- Children acquire and use knowledge and skills.
- Children take appropriate action to meet their needs.

These children must be assessed and given a rating score for each outcome. Annual reassessments must also include a rating score and a progress score for each outcome. The Child Outcome Ratings and Progress Scores provide definitions for each potential score. The scores must be recorded on the Child Outcomes Summary Form at each assessment and entered into the EI data system.

Process for Measuring Child Outcomes

1. Plan initial or annual evaluation/assessment: the *who, what, where, when, and how* to get appropriate family and provider input in order to:
   - Determine eligibility (if needed)
   - Assess functional skills in all domains
   - Assess and score each of the child outcomes

2. Complete evaluation/assessment and include as part of the assessment or IFSP meeting:
   - Verbal feedback to the family regarding the child's functioning including the areas in the child outcome statements
   - Written assessment on the IFSP pages
   - Documentation on the Child Outcomes Summary Form and in the data system.

3. During the last 3 months of the Transition Process (between 33-36 months) review this information and make changes as necessary using a new Child Outcomes Summary Form. This information is helpful to the family and the receiving provider for decision-making and program planning. Update data system if needed.

Baseline Data:

Progress Data for Infants and Toddlers Exiting 2007-2008		
Outcome 1	Number	Percentage
a: Children who did not improve functioning	19	4%
b: Children who improved functioning but not sufficient to move nearer to functioning comparable to same age peers	62	14%
c: Children who improved functioning to a level nearer to same-aged peers but did not reach it	72	16%
d: Children who improved functioning to reach a level comparable to same-aged peers	108	24%
e: Children who maintained functioning at a level comparable to same-aged peers	185	41%
total	446	100%

Outcome 2	Number	Percentage
a: Children who did not improve functioning	12	3%
b: Children who improved functioning but not sufficient to move nearer to functioning comparable to same age peers	66	15%
c: Children who improved functioning to a level nearer to same-aged peers but did not reach it	74	17%
d: Children who improved functioning to reach a level comparable to same-aged peers	124	28%
e: Children who maintained functioning at a level comparable to same-aged peers	170	38%
total	446	100%

Outcome 3	Number	Percentage
a: Children who did not improve functioning	12	3%
b: Children who improved functioning but not sufficient to move nearer to functioning comparable to same age peers	76	17%
c: Children who improved functioning to a level nearer to same-aged peers but did not reach it	78	17%
d: Children who improved functioning to reach a level comparable to same-aged peers	147	33%
e: Children who maintained functioning at a level comparable to same-aged peers	133	30%
Total	**446**	**100%**

Discussion of Baseline Data:

This is the first year that the state has two points of data to review the outcomes. The data was analyzed and compared against the expected bell curve for entry data. It is believed that the data may be skewed towards the higher functioning scores. Providers are likely scoring higher than actual as an attempt to be strength-based. Technical assistance is needed in order to ensure that scores are valid and reliable.

Measurable and Rigorous Target(s):

Targets will be set once baseline data are available.

Improvement Activities/Timelines/Resources

Improvement Activities	Timelines	Resources
Develop a child outcomes workgroup to evaluate and review child outcome reports to improve validity and reliability of the scores	**Establish by 1/08 and ongoing as needed**	**Sherlock Center on Disabilities, providers, lead agency staff**
Training and technical assistance to providers, including adding child outcomes component to Introduction to EI for all new staff, and individual technical assistance to provider agencies.	**Twice annually and as needed**	**Sherlock Center on Disabilities, providers, lead agency staff**
Convene state-wide train-the-trainers session on child outcomes and program-level quality assurance procedures.	**7/08**	**Sherlock Center, Child Outcomes Workgroup, Robin Rooney.**
Provide a better 'prompt' for exit data.	**By 6/09**	**Data manager and program data staff.**
Develop and disseminate 'Behavioral Indicators and Caregiver Questions' for age ranges re: the 3 outcomes.	**By 12/08**	**Sherlock Center, Child Outcomes Workgroup.**
Create a Family Information brochure re: child outcomes.	**By 3/09**	**Sherlock Center, RI Parent Information Network, Child Outcomes**

		Workgroup.
Create a 'Child Outcomes Resource Manual' for each program site for training and technical assistance.	**By 9/09**	**Sherlock Center, Child Outcomes Workgroup.**

Monitoring Priority:

Early Intervention Services In Natural Environments

Indicator:

4. Percent of families participating in Part C who report that Early Intervention services have helped the family:

   A. Know their rights;
   B. Effectively communicate their children's needs; and
   C. Help their children develop and learn.

(20 USC 1416(a)(3)(A) and 1442)

Data Source: Family Survey 2004-2005

Measurement:

A. Percent = # of respondent families participating in Part C who report that Early Intervention services have helped the family know their rights divided by the # of respondent families participating in Part C times 100.

B. Percent = # of respondent families participating in Part C who report that Early Intervention services have helped the family effectively communicate their children's needs divided by the # of respondent families participating in Part C times 100.

C. Percent = # of respondent families participating in Part C who report that Early Intervention services have helped the family help their children develop and learn divided by the # of respondent families participating in Part C times 100.

Overview of Issue/Description of System or Process:

A critical goal of EI is to enhance the capacities of families to meet the developmental needs of their children through information sharing, education, coaching and consultation, development of professional partnerships, and advocacy. The Rhode Island Parent Information Network, which manages the parent consultant program employs parents of Children with Special Health Care Needs, enhancing opportunities for parent-to-parent support and mentoring. The parent consultant program will work with DHS to

help develop and assure family centered, community based, and culturally competent systems of care that are comprehensive, universally accessible and effective.

Every Early Intervention provider must have at least one parent consultant per 250 children enrolled in EI. Each parent consultant has had a personal experience with an Early Intervention provider. They are able to provide interested families with resources, support, information, and opportunities to connect with other families in the system, ways to get involved and workshops about a variety of topics. Parent Consultants work closely with EI staff to enhance the program by providing the "family perspective". Their role becomes especially important to many families as families prepare to transition out of EI. Parent Consultants also survey families about their experience in EI so they can provide direct feedback to providers and DHS. The information gathered will assist each certified provider, as well as DHS in identifying opportunities for improvement.

The Early Childhood Outcomes Center family survey was utilized to gather information regarding family outcomes. The Rhode Island Parent Information Network took the lead in dissemination, collection, and data analysis required for this indicator. The Lead Agency provided mailing labels and envelopes for all active families in EI. The labels are printed with a color code to identify the specific EI Provider.

The labels are carefully inspected and the family duplicates or triplicates are taken out and noted. Wrong or incomplete addresses are investigated and corrected. A cover letter explains the survey and an optional demographics page is included. The surveys are anonymous and hand delivered by the service coordinators to all families involved with EI. A self-addressed stamped envelope to be returned to the Parent Consultant Program is also provided. The surveys are sent out in English and Spanish determined through the statewide data system (primary language). All family labels with DCYF addresses are noted and separated by EI Provider as well. The labels with DCYF addresses are given to the Parent Consultants, who identify the family's Service Coordinator who hand delivers the survey to the family on their next visit. Service Coordinators and parent consultants were made available to assist families as needed.

Aggregated information from the return surveys will include: number of returns, number of undeliverable addresses, DCYF involvement, EI Provider, Language (English or Spanish), time in EI, income, diagnosis, who is completing the survey, scoring from the individual questions, and family comments. This information is aggregated by program and statewide. Any identifiable information is taken out (family/child names, specific staff names).

Surveys were disseminated in the Fall 2006 to collect family outcomes data for the 2005-2006 review period.

Baseline Data:

A. 82.9% of respondent families participating in Part C reported that Early Intervention services have helped the family know their rights

B. 88.5% of respondent families participating in Part C reported that Early Intervention services have helped the family effectively communicate their children's needs.

C. 89.2% of respondent families participating in Part C reported that Early Intervention services have helped the family help their children develop and learn.

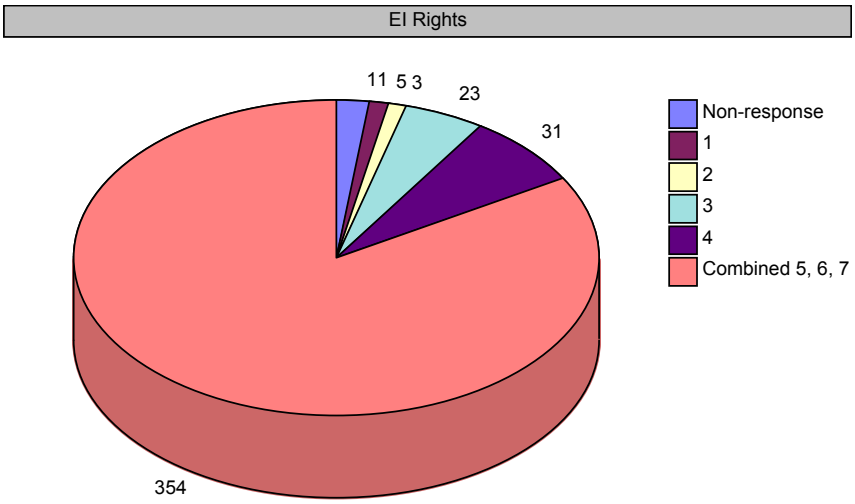
Discussion of Baseline Data:

Survey Language And Agency	Trudeau	Meeting Street	Family Resource Community Action	Maher Center	Hasbro	Family Service	Children's Friend and Service	Easter Seals	**Statewide**
English Delivered	499	329	151	61	168	131	68	16	**1423**
English Returned	128	83	67	30	36	45	13	9	**411**
English Return Rate	25.65%	25.23%	44.37%	49.18%	21.43%	34.35%	19.12%	56.25%	**28.88%**
Spanish Delivered	5	34	11	1	22	22	35	0	**130**
Spanish Returned	2	2	1	0	3	3	5	0	**16**
Spanish Return Rate	40.00%	5.88%	9.09%	0.00%	13.64%	13.64%	14.29%	NA	**12.31%**
Total Delivered	504	363	162	62	190	153	103	16	**1591**
Total Returned	130	85	68	30	39	48	18	9	**427**
Total Return Rate	**25.79%**	**23.42%**	**41.98%**	**48.39%**	**20.53%**	**31.37%**	**17.48%**	**56.25%**	**26.84%**

Early Childhood Outcomes Family Survey Questions and Responses

Q#16: To what extent has early intervention helped your family know and understand your rights?	N° cit.	Percent
1	5	1.20 %
2	3	0.72 %
3	23	5.53 %
4	31	7.45 %
Combined 5, 6, 7	354	85.10 %
TOTAL OBS.	416	100.00 %

Non-response rate for Question #16 was 2.6% (11)

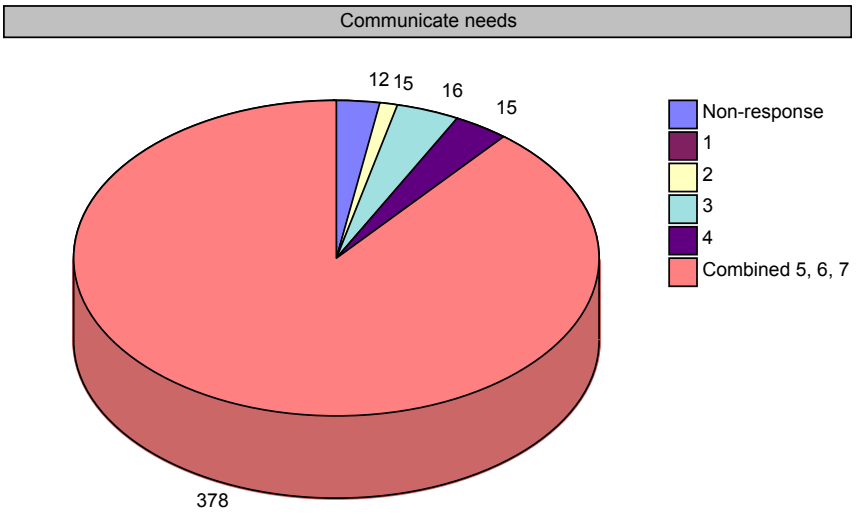


Q#16: To what extent has early intervention helped your family know and understand your rights?

Agency	**Percentage**
Easter Seals, RI	66.6 %
James L. Maher Center	86.7 %
Family Resources Community Action	89.7 %
Meeting Street	77.7 %
Hasbro Children's Hospital	92.3 %
Family Service	85.4 %
J. Arthur Trudeau Memorial Center	79.2 %
Children's Friend & Services	83.3 %
Statewide	82.9 %

Q#17: To what extent has early intervention helped your family effectively communicate your child's needs?	N° cit.	Percent
1	1	0.24 %
2	5	1.20 %
3	16	3.86 %
4	15	3.62 %
Combined 5, 6, 7	378	91.08 %
TOTAL OBS.	415	**100.00%**

Non-response rate for Question #16 was 2.8% (12)

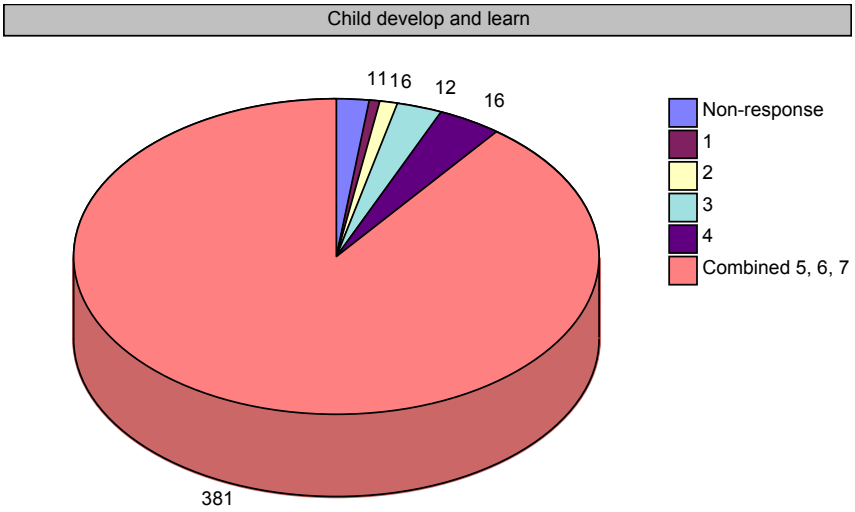


Q#17: To what extent has early intervention helped your family effectively communicate your child's needs?

Agency	**Percentage**
Easter Seals, RI	66.5 %
James L. Maher Center	93.3 %
Family Resources Community Action	91.2 %
Meeting Street	87.1 %
Hasbro Children's Hospital	94.9 %
Family Service	89.6 %
J. Arthur Trudeau Memorial Center	87.7 %
Children's Friend & Services	77.7 %
Statewide	**88.5 %**

Q#18: To what extent has early intervention helped your family be able to help your child develop and learn?	N° cit.	Percent
1	1	0.24 %
2	6	1.44 %
3	12	2.88 %
4	16	3.85 %
Combined 5, 6, 7	381	91.59 %
TOTAL OBS.	416	100.00 %

Non-response rate for Question #16 was 2.6% (11)



Q#18: To what extent has early intervention helped your family be able to help your child develop and learn?

Agency	**Percentage**
Easter Seals, RI	77.7 %
James L. Maher Center	96.7 %
Family Resources Community Action	91.2 %
Meeting Street	88.2 %
Hasbro Children's Hospital	92.3 %
Family Service	87.5 %
J. Arthur Trudeau Memorial Center	89.2 %
Children's Friend & Services	77.8 %
Statewide	**89.2 %**

Please note: That questions 16, 17, and 18 (a total of 419/427 responded) regarding time in EI are reported as a percentage based on 5, 6 and 7 combined. These questions do not currently capture age of child when referred.

Non-response is factored in the percentages below.

- 108/427 families reported that they had been in EI **less than I year**

Q16 87.9%	Q17 91.5%	Q18 89.8%

- 214/427 reported that they had been in EI for **1-2 years**

Q16 83.6%	Q17 91.3%	Q18 91.3%

- 88/427 reported that they had been in EI **2-3 years**

Q16 85.05%	Q17 90.8%	Q18 94.3%

- 9/427 reported that they had been involved with EI **over 3 years** (had transitioned out)

Q16 88.8%	Q17 77.7% *only 9 responses- the remainder , 22.2% chose #4	Q18 100%

DEMOGRAPHIC INFORMATION - EARLY INTERVENTION SURVEY

Person completing this survey		
Non response	6	1.41%
Mother	374	87.59%
Father	22	5.15%
Other	25	5.85%
Total	427	100.00%

Your child's age when first referred to EI?		
Non response	4	0.94%
Birth to 1 year	210	49.18%
1-2 years	144	33.72%
2-3 years	69	16.16%
Total	427	100.00%

Your Child's age now		
Non response	5	1.17%
Birth to 1 year	36	8.43%
1-2 years	124	29.04%
2-3 years	212	49.65%
Over 3 years	50	11.71%
Total	427	100.00%

Years in EI		
Non response	7	1.64%
Less than 1 year	108	25.29%
1-2 years	215	50.35%
2-3 years	88	20.61%
Over 3 years	9	2.11%
Total	427	100.00%

This is my:		
Non response	9	2.11%
1st child in EI	338	79.16%
2nd child in EI	59	13.82%
3rd child in EI	21	4.92%
Total	427	100.00%

Child's race/ethnicity?		
Non response	14	3.28%
American Indian or Alaskan Native	5	1.17%
Asian or Pacific Islander	10	2.34%
Black or African American	17	3.98%
Hispanic/Latino	31	7.26%
White	313	73.30%
Multi-racial	37	8.67%
Total	427	100.00%

Child's primary reason why he/she is in EI or disability/diagnosis?		
Non response	9	1.88%
Developmental Delay	81	16.91%
Prematurity	73	15.24%
Speech/language delay	171	35.70%
Visual/ blindness	5	1.04%
Autism/PDD	11	2.30%
Behavior/Emotional	9	1.88%
Gross motor delay	34	7.10%
Specific Diagnosis	80	16.70%
Total	479	100.00%

How many years of school have you completed?		
Non response	13	3.04%
Less than 8	10	2.34%
9 - 11	21	4.92%
Completed High School or GED	133	31.15%
Completed graduate studies	84	19.67%
Total	427	100.00%

Which group best describes your annual household income		
Non response	31	7.26%
Less than $15,000	64	14.99%
$15,001 - $25,000	30	7.03%
$25,001 - $30,000	28	6.56%
$30,001 - $40,000	35	8.20%
Over $40,001	239	55.97%
Total	427	100.00%

Measurable and Rigorous Target(s):

	A	B	C
2007 Target	85.5%	91.5%	92.5%
2008 Target	86.0%	92.0%	93.0%
2009 Target	86.5%	92.5%	93.5%
2010 Target	87.0%	93.0%	94.0%
2011 Target	87.5%	93.5%	94.5%

Improvement Activities/Timelines/Resources

- Beginning with the next annual family survey, include age of child when referred to demographic question in order to improve ability to analyze data.
- DHS will meet with each program annually to review survey return rates & outcome data. DHS will open discussion regarding what went well, contributing factors to survey return rates and brainstorm ways to improve return rates.
- DHS will share outcome data with all certified EI programs annually and provide TA regarding use of data to improve outcomes, such as incorporating survey questions into regular conversations with families.
- DHS will revise paperwork/IFSP to incorporate family outcomes into routine conversations and interventions with family by August 2007.

Monitoring Priority:

Effective General Supervision Part C / Child Find

Indicator:

5. Percent of infants and toddlers birth to 1 with IFSPs compared to:

A. Other States with similar eligibility definitions; and

B. National data.

(20 USC 1416(a)(3)(B) and 1442)

Measurement:

A. Percent = # of infants and toddlers birth to 1 with IFSPs divided by the population of infants and toddlers birth to 1 times 100 compared to the same percent calculated for other States with similar (narrow, moderate or broad) eligibility definitions.

B. Percent = # of infants and toddlers birth to 1 with IFSPs divided by the population of infants and toddlers birth to 1 times 100 compared to National data.

Data Source: Data collected for reporting under section 618 (Annual Report of Children Served).

Overview of Issue/Description of System or Process:

1. DHS has a cooperative agreement with the Department of Health (DOH) who contracts with the Visiting Nurses Associations (VNA) and the 7 birthing hospitals throughout the state to serve as the primary mechanism through which universal screening is conducted. An assessment (Level I screening) is conducted for each child born, which includes: child characteristics, parental demographics, parental characteristics, and established conditions. This data is collected to identify low resource, vulnerable families, identify children with known established conditions, and to identify any family that might desire support or benefit from community resources.

Infants with known established conditions are referred by the hospital to Early Intervention and children with multiple established conditions are referred for home visiting to the Family Outreach Program for a Level II screening. Visiting nurses are trained to conduct a screening that gathers information of the child's developmental competence, family strengths, needs, and support systems, and the characteristics of the care giving environment. Upon completion of this in-home screening, the FOP refers identified families to EI when appropriate or to other community based services and supports.

Additionally, DHS' view of effective community collaboration extends to building and utilizing appropriate community services and supports for young children and their families. EI is one link in such a network. Other links may include: Family Outreach Programs/VNA; CEDARR Family Centers; (Comprehensive, Education, Diagnosis, Assessment, Referral, and Re-evaluation for Children with Special Health Care Needs) Child and Adolescent Service System Program (CASSP); primary care physicians; Women, Infants and Children (WIC); RIte Care and services provided under commercial health plans; Department of Human Services Programs; Head Start/Early Head Start Programs; and child care providers.

At a minimum, EI providers must be able to demonstrate receiving and making referrals to appropriate community services and supports. Those children who are evaluated and found ineligible for EI services will be referred to appropriate programs that will benefit the child and family, such as Early Head Start, etc., given family consent. Once the referral is made, it is the responsibility of the EI service coordinator to assure appropriate follow-up. Technical assistance regarding community services and supports will be available through training sponsored by DHS. Referrals to community services and supports will be entered into the EI data system.

When community services and supports are identified in a child's IFSP, the EI provider is responsible for demonstrating service coordination with that agency or program. Other activities, such as consultation to an agency, may also be appropriate when included in the IFSP in order to ensure the appropriate modifications or accommodations have been made to assure maximum participation by the child in that agency's program. This would be included under the category of "other" on the IFSP.

Each community has unique programs and supports available. Such programs and supports may be available through libraries, churches, community centers, local social service agencies, hospitals, etc. It is the responsibility of EI providers to develop knowledge of such community supports and facilitate families in accessing them.

If a child is placed in a community setting in order to meet an IFSP goal, then the means by which EI will provide support to that setting must be delineated in a general MOA that is developed between EI and the community setting. The specifics regarding the strategies to facilitate the child's involvement in the community setting will be defined in the IFSP, as well as the payment source if one is indicated.

Building community networks often involves interacting with other community agencies or organizations around community issues, ideas or projects that are not directly related to an individual child and thus are not directly billable. As participation in such interactions ultimately benefits children and their families, EI providers have a responsibility to engage in community activities.

In addition, EI providers must participate in activities to build public awareness about the Early Intervention system and to build relationships with community agencies. This may be done, for example, through presentations to the local pediatric community, through presentations to local child care settings, collaboration in a play group with local Parents

as Teachers Program, serving on a Board for Head Start, as outreach to a local parent group, etc. Participation in all public awareness activities must be documented and available for the DHS review. Community participation will be considered as a key factor in the certification process. Technical assistance around public awareness is available through DHS.

2. Early Intervention is one program in a continuum of care system. DHS strives to integrate families of Children with Special Health Care Needs to the most appropriate programs and services within this system. Below is an example of our collaboration efforts:

a) Early Intervention and CEDARR Collaboration

All CEDARR Family Centers (CEDARR stands for **C**omprehensive, **E**valuation, **D**iagnosis, **A**ssessment, **R**eferral and **R**eevaluation) provide information and support services to families of Children with Special Health Care Needs. Linking families to appropriate resources (e.g., clinical specialists or services) and providing time-limited care coordination are central aspects of the CEDARR system of care.

The CEDARR Program Initiative includes two broad delivery system components:

- CEDARR Family Centers, and
- CEDARR Certified Direct Services (e.g., Home Based Therapeutic Services (HBTS), Kids Connect, formerly known as Therapeutic Child and Youth Care, and Personal Assistance Services and Supports (PASS)).

The CEDARR Family Center Certification Standards more fully describe the role of the CEDARR Family Centers and the related Certification Standards. They are available on line on the DHS website reached at www.dhs.ri.gov

CEDARR Direct Services are specific services developed pursuant to the CEDARR Initiative and available to Medicaid beneficiaries when included as part of an approved CEDARR Family Center Family Care Plan. Development of CEDARR Direct Services is based on two principles:

1) Identification of current service needs and gaps in health care services for children and families with special health care needs; and

2) Establishment and operation of an accountable system for the purchase of appropriate, high quality services to meet those needs.

The CEDARR Family Centers are intended to serve as "family-centered, comprehensive sources of information, clinical expertise, connection to community supports, and assistance to aid the family". The CEDARR Family Centers will be required to coordinate their efforts with Early Intervention Providers and the Early Intervention Providers are required to coordinate their efforts with the CEDARR Family Centers and

these efforts must be documented in both the IFSP and CEDARR Family Center's Family Care Plan (FCP).

CEDARR Family Centers will be integral to the successful integration of the Early Intervention System into DHS' ongoing programs and initiatives following its transition from HEALTH. When an EI provider and a CEDARR Family Center are concurrently involved with a family, there must be ongoing communication and collaboration to

ensure a seamless and comprehensive system for families of Children with Special Health Care Needs.

CEDARR Family Centers and EI providers are required to make appropriate referrals and coordinate with each other.

b) Collaboration between EI Certified Providers and EI Specialty Providers

EI Specialty providers are agencies that DHS' has agreements with in order to assure the provision of services that meet the specialized needs of children and families, such as Autism Spectrum Disorders, Mental Health services, Vision and Hearing services. Certified EI providers must refer to EI specialty providers when indicated based on child and family needs, given parental consent. The child's multidisciplinary team evaluation/assessment and IFSP should accompany the referral to the specialty provider.

Once the referral has been accepted by the specialty provider, the child's EI service coordinator and designated staff from the specialty program must schedule a co-visit with the family. The purpose of this co-visit is to clearly identify how the specialty provider will address the needs identified in the referral. It is expected that certified and specialty providers will collaborate continually through the exchange of information. Services provided by the specialty provider must be documented in the IFSP and entered into the EI data system.

The EI service coordinator will be responsible for the coordinating the scheduling of all activities with the specialty provider and the family to maximize communication. When a specialty provider participates in the provision of an EI service, he/she is considered part of the multidisciplinary team. The certified EI provider *and* the Specialty provider must bill individually for their respective staff members who are providing each service and each must enter data into the EI data system.

Specialty providers can participate in and bill for the following:

- Evaluation
- Assessment
- IFSP Development
- IFSP Review
- Specialty services applicable to needs of the populations being served (as determined by DHS*)
- Transition

*MOAs with Specialty providers are not required. However, DHS has separate agreements with each Specialty provider to determine what specialty services are billable.

If a child is referred to a specialty provider, and is not enrolled in a certified EI provider site, the specialty provider will obtain parental permission to make a referral to a certified EI provider within two days.

c) Early Intervention and Collaboration with the 'Medical Home'

A medical home provides health care services that are accessible, family-centered, continuous, and culturally competent.

It is the responsibility of a certified EI provider to collaborate with a child and family's' medical home or to work with a family to establish a medical home. EI providers must communicate with primary health care providers around desired outcomes of evaluation, assessment, and services provided. A commitment to share information is required by EI providers in order to enhance quality of services delivered to the child and family.

Additionally, DHS believes public awareness and child find activities to be complementary processes. Public awareness is an ongoing, systematic approach to communication with the general population, primary referral sources, and families for the purpose of raising their understanding of the community supports and services available to all eligible children and families. The goal of public awareness is to increase knowledge of the state's EI system, provide information regarding early indicators of children who may be eligible for EI system, describe available services including evaluation services, describe and publicize the Central Directory, and present referral procedures for children and families suspected of being in need of EI.

Baseline Data:

A) In 2004, Rhode Island ranks 1st (214/12,250=1.75%) out of the Moderate Eligibility Criteria states for serving eligible infants with disabilities under the age of one.

B) In 2004, Rhode Island ranks 4th (214/12240 = 1.75%)out of the fifty states and District of Columbia for serving eligible infants under age 1 with disabilities.

Discussion of Baseline Data:

This is the most current national data available from the Office of Special Education Program (OSEP). Data based on the December 1, 2004 count, updated as of October 2005.

Number (Excluding Children at Risk), Percentage (Based on 2003 Population Estimates), and Difference from
National Baseline of Infants and Toddlers Receiving Early Intervention Services
December 1, 2004
Grouped by Eligibility Criteria

STATE	0-1	POPULATION Age 0[1]	PERCENTAGE OF POPULATION
Moderate Eligibility Criteria			
New York	2,793	254,293	1.10
Rhode Island	***214***	***12,240***	***1.75***
Connecticut	441	42,876	1.03
Illinois	1,954	179,455	1.09
Idaho	349	21,032	1.66
Kentucky	251	54,312	0.46
New Jersey	629	118,575	0.53
Texas	3,054	378,946	0.81
Puerto Rico	213	58,043	0.37
Utah	365	48,004	0.76
Nebraska	192	25,787	0.74
Tennessee	528	78,752	0.67
California	5,233	537,777	0.97
Oregon	229	44,962	0.51
South Carolina	374	56,452	0.66
Georgia	754	138,108	0.55

Number (Excluding Children at Risk), Percentage (Based on 2003 Population Estimates), and Difference from
National Baseline of Children Age 0-1 Receiving Early Intervention Services
December 1, 2003

STATE	AGE 0 - 1 SERVED UNDER PART C	POPULATION Age 0[1]	PERCENTAGE OF POPULATION	DIF
Hawaii	539	18,956	2.84	1.92
Virgin Islands	42	1,672	2.51	1.59
Massachusetts	1,956	80,202	2.44	1.52
Rhode Island	***214***	***12,240***	***1.75***	***0.83***
Wyoming	114	6,600	1.73	0.81
North Dakota	129	7,488	1.72	0.80
Indiana	1,456	86,163	1.69	0.77
Idaho	349	21,032	1.66	0.74

Louisiana	1,110	67,320	1.65	0.73
Montana	170	10,738	1.58	0.66
Pennsylvania	2,113	145,759	1.45	0.53
West Virginia	289	20,649	1.40	0.48
Delaware	148	11,139	1.33	0.41
American Samoa	22	1,726	1.27	0.35
Kansas	479	38,945	1.23	0.31
Maryland	926	75,601	1.22	0.30
Oklahoma	617	50,398	1.22	0.30
New Hampshire	x	14,193	x	x
Wisconsin	782	68,647	1.14	0.22
Iowa	420	37,571	1.12	0.20
New York	2,793	254,293	1.10	0.18
Illinois	1,954	179,455	1.09	0.17
Michigan	1,396	128,830	1.08	0.16
Connecticut	441	42,876	1.03	0.11
California	5,233	537,777	0.97	0.05
South Dakota	97	10,855	0.89	-0.03
Vermont	54	6,199	0.87	-0.05
New Mexico	225	27,176	0.83	-0.09
Arkansas	311	37,667	0.83	-0.09
Alaska	83	10,150	0.82	-0.10
Texas	3,054	378,946	0.81	-0.11
Ohio	1,154	146,646	0.79	-0.13
Northern Marianas	10	1,297	0.77	-0.15
Utah	365	48,004	0.76	-0.16
Nebraska	192	25,787	0.74	-0.18
Colorado	505	67,840	0.74	-0.18
Mississippi	318	42,880	0.74	-0.18
Maine	98	13,848	0.71	-0.21
Tennessee	528	78,752	0.67	-0.25
Missouri	514	76,771	0.67	-0.25
South Carolina	374	56,452	0.66	-0.26
Florida	1,441	219,312	0.66	-0.26
Arizona	561	92,222	0.61	-0.31
Nevada	193	33,226	0.58	-0.34
Virginia	578	100,219	0.58	-0.34
District of Columbia	43	7,497	0.57	-0.35
Georgia	754	138,108	0.55	-0.37
New Jersey	629	118,575	0.53	-0.39
Oregon	229	44,962	0.51	-0.41
Washington	389	76,487	0.51	-0.41
North Carolina	600	118,874	0.50	-0.42
Alabama	291	59,756	0.49	-0.43
Kentucky	251	54,312	0.46	-0.46

Minnesota	282	68,793	0.41	-0.51
Puerto Rico	213	58,043	0.37	-0.55
Guam	x	3,535	x	x
National baseline	38,192	4,143,461	0.92	

Measurable and Rigorous Target(s):

Targets are for both A and B:

2006 Target: 1.75% of children birth through 1 with IFSP
2007 Target: 1.75% of children birth through 1 with IFSP
2008 Target: 1.75% of children birth through 1 with IFSP
2009 Target: 1.80% of children birth through 1 with IFSP
2010 Target: 1.90% of children birth through 1 with IFSP
2011 Target: 2.00% of children birth through 1 with IFSP

Improvement Activities/Timelines/Resources

1. Child Find efforts are coordinated with all state child find resources (e.g. Part B of IDEA, Maternal and Child Health {MCH}, Medicaid (EPSDT), Supplemental Security Income {SSI}, Developmental Disabilities Assistance and Bill of Rights Act), and with the assistance of the Interagency Coordinating Council (ICC), as well as those listed above. DHS assures that as a result of this coordination, unnecessary duplication of effort will be avoided and resources available to each public agency will be maximized.

Additionally, new requirements of the Child Abuse Prevention and Treatment Act (CAPTA), as enacted by Congress in 2003, require states to assure a referral for screening of children under age three (3) who were "involved in a substantiated case of child abuse or neglect" to early intervention service providers and partners funded under Part C." The CAPTA requirement helped to emphasize an already recognized need for coordination between the Department of Children, Youth and Families (DCYF) and the EI system. Protocols for systematic referrals, screening and evaluation have been developed by DCYF, in collaboration with DHS and the ICC.

The new certification standards, effective January 1, 2006, includes a Comprehensive Child Find performance standard, requiring that each EI provider provide feedback to primary referral source regarding eligibility for EI in 80% of referrals received from primary referral sources. This feedback must be provided in the form of a written communication to the primary referral source within 45 days of referral and must be documented in each child's record. Failure to provide feedback to primary referral source in 80% referrals may result in provisional certification status and associated reimbursement schedule changes.

2. A public awareness committee with collaborative membership (DHS staff, ICC representatives, RIPIN and EI providers) will work to address these responsibilities through numerous activities including:

- Development of improved and streamlined EI materials containing child find information to be distributed in public areas
- Requirements for EI providers to report current public awareness activities specific to EI system
- Outreach/education efforts to the physician/pediatrician community

Additionally, all public awareness activities complement, reinforce, and coordinate those procedures used by the Family Outreach Program (FOP) to convey information about universal screening, child care information, health care options/benefits, as well as linkages between child and family needs and community-based resources. The Parent Consultant program provides an additional opportunity for dissemination of EI communication materials and programmatic information.

To ensure the identification of all EI eligible children, including Indian children residing on a reservation within the state, infants and toddlers who are homeless, and those who are wards of the state, multiple community linkages and avenues into EI are essential. These linkages include CEDARR Family Centers, RIte Care, Head Start/Early Head Start, Universal Newborn Screening, Vulnerable Infant Program (VIP), and direct referrals from many sources, including Family Outreach Programs (FOP), pediatricians, hospitals, and families themselves.

The Public Awareness performance standard requires that the EI provider must complete and document three (3) public awareness activities in a calendar year, for example outreach work to underserved populations, health education fairs, workshops or conferences. The public awareness committee will coordinate these efforts. This is to assure that all eligible infants and toddlers are identified, evaluated, and enrolled, with particular attention to reaching those traditionally underserved and with the highest needs. EI providers must submit an annual plan to the public awareness committee and an annual report to DHS documenting public awareness activities no later than January 1st of each calendar year. Conducting less than three (3) within this prescribed timeframe may result in provisional certification status and associated reimbursement schedule changes.

Monitoring Priority:

Effective General Supervision Part C / Child Find

Indicator:

6. Percent of infants and toddlers birth to 3 with IFSPs compared to:

A. Other States with similar eligibility definitions; and

B. National data.

(20 USC 1416(a)(3)(B) and 1442)

Measurement:

A. Percent = # of infants and toddlers birth to 3 with IFSPs divided by the population of infants and toddlers birth to 3 times 100 compared to the same percent calculated for other States with similar (narrow, moderate or broad) eligibility definitions.

B. Percent = # of infants and toddlers birth to 3 with IFSPs divided by the population of infants and toddlers birth to 3 times 100 compared to National data.

Data Source: Data collected for reporting under section 618 (Annual Report of Children Served).

Overview of Issue/Description of System or Process:

Please see Indicator #5 for Overview of Issue/Description of System or Process for Indicator #6.

Baseline Data:

A. In 2004, Rhode Island ranks 2nd (1314/36866=3.56%)out of the Moderate Eligibility Criteria states for serving eligible infants with disabilities. This is the most current national data available from the Office of Special Education Program. (OSEP)

B. In 2004, Rhode Island ranks 6th (1314/36866=3.56%)out of the fifty states and District of Columbia for serving eligible infants with disabilities.

Discussion of Baseline Data:

This is the most current national data available from the Office of Special Education Program (OSEP). Data based on the December 1, 2004 count, updated as of October 2005.

Table 1

State	BIRTH Through 2 Total	Population 0-2[1]	% OF Population	Dif
Moderate Eligibility Criteria				
New York	32,232	756,205	4.26	2.02
Rhode Island	***1,314***	***36,866***	***3.56***	***1.32***
Connecticut	3,948	127,491	3.10	0.86
Illinois	15,318	535,294	2.86	0.62
Idaho	1,706	62,502	2.73	0.49
Kentucky	3,666	159,785	2.29	0.05
New Jersey	7,790	352,327	2.21	-0.03
Texas	20,641	1,121,408	1.84	-0.40
Puerto Rico	3,139	174,849	1.80	-0.44
Utah	2,515	141,906	1.77	-0.47
Nebraska	1,303	75,083	1.74	-0.50
Tennessee	3,973	232,302	1.71	-0.53
California	26,669	1,600,314	1.67	-0.57
Oregon	2,081	134,621	1.55	-0.69
South Carolina	2,289	167,751	1.36	-0.88
Georgia	5,450	411,041	1.33	-0.91
New York	32,232	756,205	4.26	2.02

Table 2:

Number, Percentage (Based on 2003 Population Estimates), and Difference from National Baseline of Infants and Toddlers Receiving Early Intervention Services December 1, 2004

STATE	BIRTH THROUGH 2 TOTAL	POPULATION 0-2[1]	PERCENTAGE OF POPULATION	DIF
Hawaii	3,936	55,480	7.09	4.79
Massachusetts	13,757	239,325	5.75	3.45
New York	32,232	756,205	4.26	1.96
Indiana	10,738	255,744	4.20	1.90
Wyoming	759	19,081	3.98	1.68
Rhode Island	***1,314***	***36,866***	***3.56***	***1.26***
Virgin Islands	178	5,087	3.50	1.20
New Mexico	2,760	80,714	3.42	1.12
West Virginia	1,985	60,914	3.26	0.96
Vermont	600	18,606	3.22	0.92
Connecticut	3,948	127,491	3.10	0.80
Pennsylvania	13,297	432,315	3.08	0.78
Delaware	1,006	32,810	3.07	0.77

Arkansas	3,283	111,706	2.94	0.64
Maine	1,169	40,683	2.87	0.57
Illinois	15,318	535,294	2.86	0.56
South Dakota	897	31,624	2.84	0.54
Wisconsin	5,756	203,618	2.83	0.53
North Dakota	611	21,842	2.80	0.50
Maryland	6,276	225,878	2.78	0.48
Idaho	1,706	62,502	2.73	0.43
New Hampshire	1,164	43,104	2.70	0.40
Kansas	2,947	114,457	2.57	0.27
Louisiana	4,522	196,629	2.30	0.00
Kentucky	3,666	159,785	2.29	-0.01
New Jersey	7,790	352,327	2.21	-0.09
Michigan	8,350	386,170	2.16	-0.14
Montana	677	31,787	2.13	-0.17
Iowa	2,331	109,781	2.12	-0.18
Oklahoma	3,013	147,755	2.04	-0.26
Alaska	610	30,150	2.02	-0.28
Florida	12,214	655,203	1.86	-0.44
Texas	20,641	1,121,408	1.84	-0.46
Ohio	7,991	435,667	1.83	-0.47
California	28,781	1,600,314	1.80	-0.50
Puerto Rico	3,139	174,849	1.80	-0.50
Virginia	5,369	299,736	1.79	-0.51
Utah	2,515	141,906	1.77	-0.53
Nebraska	1,303	75,083	1.74	-0.56
North Carolina	6,123	357,551	1.71	-0.59
Tennessee	3,973	232,302	1.71	-0.59
Colorado	3,484	204,418	1.70	-0.60
Mississippi	2,126	125,719	1.69	-0.61
Washington	3,859	230,108	1.68	-0.62
Oregon	2,081	134,621	1.55	-0.75
Arizona	4,196	272,730	1.54	-0.76
Missouri	3,445	225,324	1.53	-0.77
Minnesota	3,039	202,070	1.50	-0.80
Guam	152	10,218	1.49	-0.81
South Carolina	2,289	167,751	1.36	-0.94
Georgia	5,450	411,041	1.33	-0.97
Northern Marianas	47	3,600	1.31	-0.99
District of Columbia	288	22,101	1.30	-1.00
Nevada	1,308	100,764	1.30	-1.00
American Samoa	63	4,856	1.30	-1.00
Alabama	2,261	176,839	1.28	-1.02
National baseline	282,733	12,311,909	2.30	

Measurable and Rigorous Target(s):

Targets are for both A and B:

2006 Target: 3.60% of children birth through 3 with IFSP
2007 Target: 3.60% of children birth through 3 with IFSP
2008 Target: 3.70% of children birth through 3 with IFSP
2009 Target: 3.70% of children birth through 3 with IFSP
2010 Target: 3.80% of children birth through 3 with IFSP
2011 Target: 3.80% of children birth through 3 with IFSP

Improvement Activities/Timelines/Resources

In addition to activities/timelines/resources listed in Indicator #5, DHS will utilize its contracts in the development, planning and dissemination of public awareness materials for all Children with Special Health Care Needs (CSHCN) receiving services through DHS and their families. Contractors will provide support and technical assistance in public awareness activities/workgroups of all certified DHS programs serving CSHCN and their families.

Monitoring Priority:

Effective General Supervision Part C / Child Find

Indicator:

7. Percent of eligible infants and toddlers with IFSPs for whom an evaluation and assessment and an initial IFSP meeting were conducted within Part C's 45-day timeline.

(20 USC 1416(a)(3)(B) and 1442)

Measurement:

Percent = # of eligible infants and toddlers with IFSPs for whom an evaluation and assessment and an initial IFSP meeting was conducted within Part C's 45-day timeline divided by # of eligible infants and toddlers evaluated and assessed times 100.

Account for untimely evaluations.

Data Source: Data to be taken from monitoring or State data system and must address timeline from point of referral to initial IFSP meeting based on actual, not an average, number of days.

Overview of Issue/Description of System or Process:

DHS requires comprehensive multidisciplinary evaluations/assessments of the child as well as a family assessment, with the consent of the family, are conducted in a timely manner in order to assure an initial IFSP meeting be held within 45 days of referral. Certified EI providers must demonstrate that evaluations and assessments are conducted in collaboration with other agencies where indicated. Written prior notice is required to conduct evaluations/assessments and must be documented in the child's record.

The service coordinator, who coordinates the evaluation and assessment process, assumes responsibility for the following activities:

- Serving as the single point of contact in assisting parents to obtain required services and assistance
- Assisting parents in gaining access to all services identified in the IFSP
- Coordinating the provision of services both within and across agencies
- Facilitating the timely delivery of services
- Coordinating the performance of assessments
- Facilitating the development, review, and appropriate modification of the IFSP
- Assisting families in identifying available service providers external to EI providers
- Coordinating with medical and health care providers
- Facilitating the development of appropriate transition plans

Qualified multidisciplinary team members, trained to use appropriate methods and procedures, conduct evaluations and assessments. The evaluation for eligibility determination includes a review of medical history and the use of two or more measures, including norm-referenced, criterion-referenced, parent report, and/or direct observational measures. A family assessment must be completed and documented in IFSP with family consent.

Evaluation and assessment measures used must provide information about the child's level of functioning in each of the following areas: cognition, physical development, including vision and hearing; communication; social and emotional development and adaptive development. Emphasis must be placed on assessing and describing the child's participation in family routines and everyday activities, and not merely his/her 'testing performance'.

Evaluation/Assessment Tools

If the evaluation and assessment process are combined initially, as may be the case when eligibility must be determined, at least one measure used in the evaluation and assessment must be norm-or criterion-referenced. A norm-referenced test is a test that compares the individual child's performance to a clearly defined normative group (i.e., comparing a two year old child's performance to that of a thousand other two year olds on the same tasks). A criterion-referenced measure compares an individual's performance to established criterion or standard of performance. In most cases use of both a norm-referenced and criterion-referenced measure will provide the most complete information to determine eligibility and begin assessment of a child's current functioning for program planning.

If a criterion-referenced tool is used for the determination of eligibility, it must provide a developmental age or ages in the required domains. If a child has been referred to EI at 28 months of age or older, it is critical that norm-referenced measures be considered and that the evaluation be coordinated with the LEA so it may also be used for eligibility determination for preschool special education services. Selection of the other tool(s) is based on the judgment of the evaluation team with family input as appropriate. In cases where eligibility is known, as is the case with a documented established condition (SEC), it is recommended that criterion-referenced measures be used to link the assessment to goals in the IFSP. Descriptive and specific documentation in the IFSP is required in order to justify the concern of the team and the need for EI services.

Use of Outside Evaluations

EI providers must use evaluations completed by other agencies in eligibility determination if they meet the evaluation/assessment requirements and have been completed in the last three months. The evaluation/assessment requirements are: completed by two qualified professionals, completed using at least two measures, and consideration of the five domains. If these evaluations do not meet the evaluation

standards or have not been completed within the last three months, additional evaluations are to be completed if the child is not eligible based on a single established condition. However, when an outside evaluation is used to determine eligibility, EI must still complete an assessment for the development of the IFSP. This assessment must be

conducted by a multidisciplinary team of at least two qualified personnel. If an outside evaluation also contains information that may be appropriate for IFSP development, such information must be reviewed and included in the IFSP. Outside evaluation must be included in the child's record.

EI evaluation teams must consider any outside evaluations that parents may have and wish to have considered; however, the EI evaluation and IFSP team hold the responsibility of determining eligibility and services. If parents, as members of the EI teams, disagree with the decisions made by other team members, then they may access procedural safeguards.

Baseline Data:

Reason	*Within 45 days*	*Within 50 days*	*Within 60 days*	*Within 70 days*	*Within 80 days*	*Within 90 days*	*Within 100 days*	*Within 110 days*	*Within 120 days*	*Within 130 days*	*Within 140 days*	*Within 150 days*	*Between 151 & 200 days*	*OVER 200*	*Total*	*Percentage*
Compliance	420														420	*26.49%
Child Illness		2		4	3	3		1	1					1	15	.94%
Family Request Delay		9	8	6	8	5	6	2	1		1	1		2	49	3.09%
Unable to contact family		7	12	22	13	13	15	8	6	2	6	2	8	1	115	7.25%
Non-compliance																
Provider Issue		37	55	45	42	30	20	11	17	5	9	3	6	3	283	17.85%
Reason Not entered		84	129	134	101	70	54	31	27	19	15	12	19	8	703	44.35%
Total	**420**	**139**	**204**	**211**	**167**	**121**	**95**	**53**	**52**	**26**	**31**	**18**	**33**	**15**	**1585**	
Total within time frame		559	763	974	1141	1262	1357	1410	1462	1488	1519	1537	1570	1585		
Percentage within time frame	26.49%	35.27%	48.14%	61.45%	71.99%	79.62%	85.62%	88.96%	92.24%	93.88%	95.84%	96.97%	99.05%	100%		

Discussion of Baseline Data:

420 /1585 x100= 26.49%

Data includes all referrals from July 1st, 2004 through June 30th, 2005. Data was gathered from the EIMIS. For this report, a query to find all referrals within the timeframe being reviewed is compared with the child's initial IFSP meeting entered into the system. If a child's first IFSP meeting is not completed within 45 days a reason why this has not occurred is entered into the system. This field was added to the EIMIS in January 2004 per OSEP's September 2004 site visit compliance letter.

Additionally, DHS prides itself on its exemplary Child Find activities that result in large number of referrals and evaluations. Between July 1st, 2004 and June 30th, 2005, a total of 2296 referrals were logged at the seven certified EI providers, approximately 191 per month.

Measurable and Rigorous Target(s):

2006 Target: An initial IFSP meeting is held for 100% of all eligible infants and toddlers within 45-days
2007 Target: An initial IFSP meeting is held for 100% of all eligible infants and toddlers within 45-days
2008 Target: An initial IFSP meeting is held for 100% of all eligible infants and toddlers within 45-days
2009 Target: An initial IFSP meeting is held for 100% of all eligible infants and toddlers within 45-days
2010 Target: An initial IFSP meeting is held for 100% of all eligible infants and toddlers within 45-days
2011 Target: An initial IFSP meeting is held for 100% of all eligible infants and toddlers within 45-days

Improvement Activities/Timelines/Resources

1. DHS recognizes its noncompliance in this area. Development of revised Certification Standards and State Rules and Regulations are an integral part of DHS' programmatic improvement process. Under the new lead agency Certification as an EI provider for reimbursement in the provision of EI services. Certification requires that providers adhere to all standards and performance expectations, as well as provide periodic reports to DHS. Revised certification standards to be implemented January 1, 2006.

Additionally, subsequent to certification, DHS will monitor the performance of certified EI providers and their continued compliance with certification requirements. Certified providers are required to notify DHS of any material changes in their organization's circumstances or in program operations. On the basis of ongoing monitoring, including review of required reports submitted by certified providers, DHS may identify deficiencies in performance and/or compliance with certification requirements. Based on such review and related communications, certification status may be modified to Provisional Certification. Fully Certified and Provisionally Certified providers may be reimbursed using different rate schedules.

The Initial IFSP Meeting performance standard requires that each EI provider, upon receipt of a referral, must appoint a service coordinator as soon as possible. An EI provider must complete the assessment and eligibility evaluation if needed, as well as the initial IFSP meeting for all eligible infants and toddlers within forty-five (45) days from referral. Use of an interim IFSP, does not change this 45 day requirement. If the evaluation and assessment cannot be completed within forty-five (45) days, EI providers must document the circumstances on the IFSP and in the EI data system. DHS requires full compliance of 100% with this indicator when the family reasons are factored into the equation. Our monitoring data shows that approximately 20% of the delays are due to family reasons. Completion of the assessment, evaluation and initial IFSP meeting within forty-five (45) days must occur for more than 80% of EI referrals. Failure to do so may result in provisional certification status and associated reimbursement schedule changes.

The Evaluation and Assessment performance standard requires that EI providers must evaluate and assess the child's level of functioning in the five domains: cognition, physical development, including vision and hearing, communication, social and emotional development and adaptive development in 100% of evaluations for eligibility and ongoing assessments. EI providers must document evidence of evaluations and assessments in the IFSP and the EI data system. Failure to evaluate and assess children in all domains 100% of the time may result in provisional certification status and associated reimbursement schedule changes.

Certified providers submit data to the statewide data system. This data is reviewed and analyzed monthly and provided to each of the certified providers during monthly meetings. Discussion and technical assistance occur as needed during each of these monthly meetings.

2. Additionally, DHS will utilize contracts to provide technical assistance in the improvement of service delivery for CSHCN. Specific activities include:

- Implement an evaluation of the Early Intervention System
- Develop trainings/technical assistance regarding operationalizing the 45 day timeline.
- Provide technical assistance to all providers by July 2006 and ongoing as needed.

3. Additionally, a substantial percentage of noncompliance with the 45-day timeline is potentially a result of "reason not entered" (44.35%). DHS recognizes the need for significant training and technical assistance around data entry. This will be provided by April 2006 and ongoing as needed.

These improvement strategies were designed in response to the letter received from OSEP on October 4th, 2005 based on RI's submission of its Federal Fiscal Year 2003 Annual Performance Report (APR).

Monitoring Priority:

Effective General Supervision Part C / Effective Transition

Indicator:

8. Percent of all children exiting Part C who received timely transition planning to support the child's transition to preschool and other appropriate community services by their third birthday including:
   A. IFSPs with transition steps and services
   B. Notification to LEA, if child potentially eligible for Part B: and
   C. Transition conference, if child potentially eligible for Part B.

(20 USC 1416(a)(3)(B) and 1442)

Measurement:

A. Percent = # of children exiting Part C who have an IFSP with transition steps and services divided by # of children exiting Part C times 100.

B. Percent = # of children exiting Part C and potentially eligible for Part B where notification to the LEA occurred divided by the # of children exiting Part C who were potentially eligible for Part B times 100.

C. Percent = # of children exiting Part C and potentially eligible for Part B where the transition conference occurred divided by the # of children exiting Part C who were potentially eligible for Part B times 100.

Data Source: Data to be taken from monitoring or State data system.

Overview of Issue/Description of System or Process:

EI providers must demonstrate that each child's transition team is comprised of: (1) the child's parent(s), (2) the EI service coordinator, (3) representative from the school department, (4) representative(s) from appropriate community services and supports as determined by the team. Written prior notice of the meeting must be given seven (7) days in advance and documented in child's record. The meeting is scheduled and convened by the service coordinator. Parent education and parent-to-parent support is given regarding the general transition process beginning when the child is approximately 24 months of age. Each family should be given a copy of "Transition from Early Intervention: A Family Guide."

At 28 months old, a notification to the appropriate LEA is made for all children potentially eligible for special education under IDEA Part B.

At 28 months old the child, with parental consent, must be referred to the LEA. The first transition-planning meeting must occur when the child is thirty months of age.

For children who may be eligible for preschool special education and who will turn three years of age between May and September, these timelines must be adjusted to ensure that six months of planning time is still available to the transition team. Therefore, all transition activities, beginning with the referral, should occur earlier (e.g., referral at 26 months instead of 28 for a child with a July birthday).

Children who are referred to EI after 28 months should be referred as soon as possible to the LEA and other community services and supports. The service coordinator should not wait for an EI evaluation/assessment to schedule the transition-planning meeting.

If a child is referred to EI at 34 months or older, the primary work of EI is to support the family through transition. The service coordinator should refer to the LEA and other community services and supports immediately and use an interim IFSP with an outcome of transitioning the child and family. In these cases, an immediate transition-planning meeting is convened with the appropriate team within two (2) weeks to decide how to evaluate the child for special education eligibility and to plan for transition into community services and supports.

If the child has a surrogate parent while in EI, the transition plan needs to include steps to ensure a timely assignment of an educational surrogate advocate. An educational advocate is accessed when the service coordinator notifies the Department of Children Youth Families (DCYF) caseworker and requests that the paper work process be initiated. This must be documented in the child's record.

In summary:

1) At 28 months, notification of potentially eligible children is made to the appropriate LEA.
2) At 28 months a referral is made to the Local Education Agency (LEA) and appropriate community services and supports, with parental consent.
3) At 30 months EI provider service coordinator will schedule and convene the transition planning meeting with appropriate transition team members as outlined in Section 5.3.6
4) Between 30 – 36 months the LEA holds an eligibility meeting
5) Between 30 – 36 months if the child is eligible for special education, the IEP meeting is convened
6) Between 30 –36 months if the child is not eligible for special education, the EI provider service coordinator and transition planning team members refer the family to appropriate community services and supports
7) Between 30-36 months ALL Medicaid eligible children must be referred to a CEDARR Family Center, given parental consent.

Transition Plan

EI providers must demonstrate that the result of the transition meeting is a written Individual Transition Plan. Written plans must include:

- Type and extent of evaluation data required to determine the child's status and eligibility for preschool programs under Part B services at age three, or referral to other appropriate community services and supports, as well as the person(s) responsible for performing the evaluations
- Procedures to prepare the child for changes in service delivery, including steps to help the child adjust to and participate in a new setting
- Family participation goals
- Parental consent for the transferring of confidential information to the LEA and/or appropriate community services and supports—including evaluation, assessment, and IFSP information
- Procedures for preparing an Individualized Education Program (IEP) and provision of those services by 36 months, if the child is deemed eligible for special education
- Specific timelines for completing the above activities

If the child is eligible for preschool special education, the LEA will convene an IEP meeting as part of the transition process. Appropriate EI staff should be invited to these meetings, with parent permission and it is appropriate that they attend. The purpose of transition planning and timelines is to ensure that there is enough time to gather the information needed for eligibility determination and for IEP development. Children who are eligible should have an IEP meeting by their third birthday in order to have services begin right away, or on the first day of school following a summer birthday. Some children will be recommended for a more intensive extended school day or school year placement. Only an IEP team can decide if a child is eligible for preschool special education and "extended school day or year" services.

Baseline Data:

A. 77% of children exiting Part C had an IFSP with transition steps and services.

B. 93% of children exiting Part C and potentially eligible for Part B had a notification to the LEA.

C. 91% of children exiting Part C and potentially eligible for Part B had a transition conference

Discussion of Baseline Data:

This data was taken by sampling. The sample consists of all children who were discharged between July 1st, 2004 and June 30th, 2005 who were older than 34 months at the time of discharge. Five percent of those children were randomly selected from each agency for a review of their transition plan (965 x .05=49). Children that left the system before transition occurred or before transition was completed were taken out of the count.

Provider	Sample Size	IFSP Steps A.	Notification B.	Conference C.
Children's Friend and Service	4	3/3	3/3	3/3
Family Resources Community Action	6	4/5	6/6	5/5
Family Services	4	3/3	4/4	3/3
Hasbro Children's Hospital	4	4/4	4/4	4/4
James L. Maher Center	3	3/3	3/3	3/3
Meeting Street Center	12	5/10	9/11	7/10
Trudeau Memorial Center	16	12/16	14/15	14/15
Total	**49**	**34/44=77%**	**43/46=93%**	**39/43=91%**

A. Percent = # of children exiting Part C who have an IFSP with transition steps and services divided by # of children exiting Part C times 100.

B. Percent = # of children exiting Part C and potentially eligible for Part B where notification to the LEA occurred divided by the # of children exiting Part C who were potentially eligible for Part B times 100.

C. Percent = # of children exiting Part C and potentially eligible for Part B where the transition conference occurred divided by the # of children exiting Part C who were potentially eligible for Part B times 100.

Measurable and Rigorous Target(s):

A. Percentage of children exiting Part C who have an IFSP with transition steps and services.

2006 Target: 100%
2007 Target: 100%
2008 Target: 100%
2009 Target: 100%
2010 Target: 100%
2011 Target: 100%

B. Percent of children exiting Part C and potentially eligible for Part B where notification to LEA occurred.

2006 Target: 100%
2007 Target: 100%
2008 Target: 100%
2009 Target: 100%
2010 Target: 100%
2011 Target: 100%

C. Percent of children exiting Part C and potentially eligible for Part B where transition conference occurred.

2006 Target: 100%
2007 Target: 100%
2008 Target: 100%
2009 Target: 100%
2010 Target: 100%
2011 Target: 100%

Improvement Activities/Timelines/Resources

1. The transition of EI to DHS created an opportunity for the synergy of CSHCN programs administered by DHS. It is recognized that coordination of transition services offers an opportunity for system improvement. DHS will utilize contracts to facilitate this process beginning February 2006, which will include:

- DHS in collaboration with its contractors will provide individualized and programmatic technical assistance to families, early childhood providers, school district staff, Pediatricians, CEDARR Family Centers, EI service coordinators, and parent consultants in regards to transitioning from Early Intervention.
  - ❖ Responsible for maintaining, updating, printing and disseminating "Transition from EI: A Family Guide", which must include information for families transitioning from EI to Special Education and for families not eligible for Special Education services transitioning to community services.
  - ❖ Participate in the Introduction to Early Intervention course as it relates to training on transition, twice annually.
  - ❖ Train and support transition mentors in each of the certified EI programs, regarding transition to Special Education and other resources, supports, and services.
  - ❖ Facilitate group interaction between Early Childhood Providers to strengthen linkages (Primary Care Providers, CFC, Child Care, EI, etc.)

- ❖ Develop and conduct training on transition for EI parent consultants twice annually, including transition to Special education and other resources, supports, and services.
- ❖ Develop and conduct training on transition for EI families twice annually, including transition to Special Education and other resources, supports, and services.
- ❖ Responsible for revising, disseminating, collecting, and analyzing data from EI transition surveys and providing this information to DHS quarterly.
- ❖ Collaborate with all possible referral sources for children at age three (3), including DHS certified programs, Part B (preschool programs receiving funding under Section 619) and other appropriate programs serving children and families at age three (3). Documentation of collaboration efforts to be maintained by contractor and reported to DHS every six (6) months.

- DHS in collaboration with its contractors will provide information and training regarding EI transition needs and guidelines to CEDARR Family Centers, Head Start, Child Care and other community-based providers.

2. DHS will provide an annual training for all DHS providers serving Children with Special Health Care Needs regarding statewide resources/community options for families.

3. Additionally, a transition performance standard requires that the EI provider must implement a timely transition plan to support infant and toddlers transition to pre-school and appropriate community services and supports. Implementing less than 90% of transition plans according to timelines may result in provisional certification status and associated reimbursement schedule changes. Documentation must be provided in the IFSP and EI data system. This standard will be monitored on a monthly basis beginning January 2006.

Revised/new improvement activity as of 2/1/08:

New Transition Forms to be implemented for all transitions by March 2008.

Monitoring Priority:

Effective General Supervision Part C / General Supervision

Indicator:

9. General supervision system (including monitoring, complaints, hearings, etc.) identifies and corrects noncompliance as soon as possible but in no case later than one year from identification.

(20 U.S.C. 1416(a)(3)(B) and 1442)

Measurement:

A. Percent of noncompliance related to monitoring priority areas and indicators corrected within one year of identification:
   a. # of findings of noncompliance made related to priority areas.
   b. # of corrections completed as soon as possible but in no case later than one year from identification.

   Percent = b divided by a times 100.

   For any noncompliance not corrected within one year of identification, describe what actions, including technical assistance and/or enforcement that the State has taken.

B. Percent of noncompliance related to areas not included in the above monitoring priority areas and indicators corrected within one year of identification:
   a. # of findings of noncompliance made related to such areas.
   b. # of corrections completed as soon as possible but in no case later than one year from identification.

   Percent = b divided by a times 100.

   For any noncompliance not corrected within one year of identification, describe what actions, including technical assistance and/or enforcement that the State has taken.

C. Percent of noncompliance identified through other mechanisms (complaints, due process hearings, mediations, etc.) corrected within one year of identification:
   a. # of EIS programs in which noncompliance was identified through other mechanisms.
   b. # of findings of noncompliance made.
   c. # of corrections completed as soon as possible but in no case later than one year from identification.

   Percent = c divided by b times 100.

For any noncompliance not corrected within one year of identification, describe what actions, including technical assistance and/or enforcement that the State has taken.

Data Source: Data to be taken from State monitoring, complaints, hearings and other general supervision system components. Indicate the number of EIS programs monitored related to the monitoring priority areas and indicators and the number of EIS programs monitored related to areas not included in the monitoring priority areas and indicators.

Overview of Issue/Description of System or Process:

Consistent with the Individuals with Disabilities Education Act (IDEA) 34 CFR Part 303 (Part C), the Department of Human Services (DHS) has defined a set of standards to ensure compliance with federal and state regulations and to ensure the provision of quality services to the infants and toddlers and their families in the State of Rhode Island. This certification process and the issuance of these Certification Standards provide the basis for DHS determination of providers eligible to participate in and receive payment for the provision of EI services. These Certification Standards establish the procedures and requirements for EI services as administered by DHS. These Certification Standards serve to provide families, potential applicants, service providers and other interested parties with a full description of Early Intervention Services, including guidance related to certification requirements, methods for application, and evaluation requirements.

Baseline Data:

A(a). 24 findings of non-compliance made related to priority areas.
A(b). 0 corrections completed as soon as possible but in no case later than one year from identification

24 findings where the timeline is not up yet.

0/24 x 100 = 0 noncompliance

Indicator #1	**Non-Compliant**	**Compliant**
Children's Friend and Service	x	
Family Service	x	
Family Resources	x	
Maher Center	x	
Trudeau Memorial	x	
Meeting Street Center	x	
Hasbro	x	
Indicator #7		
Children's Friend and Service	x	
Family Service	x	
Family Resources	x	
Maher Center	x	
Trudeau Memorial	x	
Meeting Street Center	x	
Hasbro	x	
Indicator #8		
Children's Friend and Service		x
Family Service		x
Family Resources	x	

Maher Center		x
Trudeau Memorial	x	
Meeting Street Center	x	
Hasbro		x
Indicator #9		
Children's Friend and Service	x	
Family Service	x	
Family Resources	x	
Maher Center	x	
Trudeau Memorial	x	
Meeting Street Center	x	
Hasbro	x	
Indicator #10		
Children's Friend and Service		x
Family Service		x
Family Resources		x
Maher Center		x
Trudeau Memorial		x
Meeting Street Center		x
Hasbro		x
Indicator #11		
Children's Friend and Service		x
Family Service		x
Family Resources		x
Maher Center		x
Trudeau Memorial		x
Meeting Street Center		x
Hasbro		x

B. Number of Early Intervention Referrals between July 1, 2004 and June 30, 2005 with a Service Coordinator Assigned

Provider	Total	SC	No SC
Children's Friend & Service	215	215	0
Family Resources Community	241	241	0
Family Services of Rhode Island, Inc.	343	342	1
Hasbro Children's Hospital	202	202	0
James L. Maher Center	152	152	0
Meeting Street Center	578	578	0
Trudeau Memorial Center	565	565	0

B(a). 1 findings of non-compliance made related to areas not included in the above monitoring areas.

B(b). 1 correction to be completed as soon as possible but in no case later than one year from identification.

100% corrected within one year.

C(a). 1 EIS program non-compliance was identified through a formal complaint.
C(b). 1 finding of non-compliance made
C(c). 1 correction completed.

100% corrected within one year.

Discussion of Baseline Data:

A. Table for Indicator #1:

Percent = # of infants and toddlers with IFSPs who receive the Early Intervention services on their IFSPs not in a timely manner divided by the total # of infants and toddlers with IFSPs times 100.

Provider	Timely	Rank
Family Resources Community Action	67/200=33%	1
Family Services	76/202=38%	2
Trudeau Memorial Center	235/626=38%	2
Children's Friend and Service	58/144=40%	3
Meeting Street Center	234/562=42%	4
James L. Maher Center	56/115=49%	6
Hasbro Children's Hospital	108/214=50%	7

Table for Indicator #7:

Percent = # of eligible infants and toddlers with IFSPs for whom an evaluation and assessment and an initial IFSP meeting not was conducted within Part C's 45-day timeline divided by # of eligible infants and toddlers evaluated and assessed times 100.

Provider	45 Day Timeline	Rank
James L. Maher Center	41/102=40.20%	1
Meeting Street Center	247/423=58.39%	2
Hasbro Children's Hospital	98/138=71.01%	3
Family Services	142/182=78.02%	4
Trudeau Memorial Center	369/450=82%	5
Children's Friend and Service	125/138=90.58%	6
Family Resources Community Action	143/152=94.08%	7

Table for Indicator #8:

A. Percent = # of children exiting Part C who have an IFSP with transition steps and services divided by # of children exiting Part C times 100.

B. Percent = # of children exiting Part C and potentially eligible for Part B where notification to the LEA occurred divided by the # of children exiting Part C who were potentially eligible for Part B times 100.

C. Percent = # of children exiting Part C and potentially eligible for Part B where the transition conference occurred divided by the # of children exiting Part C who were potentially eligible for Part B times 100.

Provider	**Rank**	**IFSP Steps (A)**	**Notification (B)**	**Conference (C)**
Children's Friend and Service	1	3/3	3/3	3/3
Family Services	1	3/3	4/4	3/3
Hasbro Children's Hospital	1	4/4	4/4	4/4
James L. Maher Center	1	3/3	3/3	3/3
Family Resources Community Action	2	4/5	6/6	5/5
Trudeau Memorial Center	3	12/16	14/15	14/15
Meeting Street Center	4	5/10	9/11	7/10
Total	**49**	**34/44=77%**	**43/46=93%**	**39/43=91%**

Table for Indicator #10:

Percent of signed written complaints with reports issued that were resolved within 60-day timeline or a timeline extended for exceptional circumstances with respect to a particular complaint.

Provider	**Timely Written Complaints**	**Rank**
Children's Friend and Service	100%	1
Family Resources Community Action	100%	1
Family Services	100%	1
Hasbro Children's Hospital	100%	1
James L. Maher Center	100%	1
Meeting Street Center	100%	1
Trudeau Memorial Center	100%	1

Table for Indicator #11:

Percent of fully adjudicated due process hearing requests that were fully adjudicated within the applicable timeline.

Agency	Timely Hearing	Rank
Children's Friend and Service	100%	1
Family Resources Community Action	100%	1
Family Services	100%	1
Hasbro Children's Hospital	100%	1
James L. Maher Center	100%	1
Meeting Street Center	100%	1
Trudeau Memorial Center	100%	1

B. 1 finding of non-compliance around Service Coordinator assignment. Correction to be completed as soon as possible but in no case later than one year from identification.

C. 1 complaint of violation of the 45-day timeline was identified through formal written communication but was corrected within 13 days. Complaint was withdrawn.

Measurable and Rigorous Target(s):

A. Percent of noncompliance related to monitoring priority areas and indicators corrected within one year of identification.

2006 Target: 100%
2007 Target: 100%
2008 Target: 100%
2009 Target: 100%
2010 Target: 100%
2011 Target: 100%

B. Percent noncompliance related to areas not included in the above monitoring priority areas and indicators corrected within one year of identification.

2006 Target: 100%
2007 Target: 100%
2008 Target: 100%
2009 Target: 100%
2010 Target: 100%
2011 Target: 100%

C. Percent of noncompliance identified through other mechanisms (complaints, due process hearings, mediations, etc.) corrected within one year of identification. .

2006 Target: 100%
2007 Target: 100%
2008 Target: 100%
2009 Target: 100%
2010 Target: 100%
2011 Target: 100%

Improvement Activities/Timelines/Resources

1. In an effort to maintain and implement a statewide, comprehensive, coordinated, multidisciplinary, interagency system of EI services for infants and toddlers with disabilities and their families, DHS requires certified EI providers to demonstrate capacity to implement all EI system components as outlined in the new EI Certification Standards effective January 1st, 2006. .

Fully certified EI providers will be in compliance with the Certification Standards and meet performance standards for EI services provided. DHS utilizes these performance standards as well as data collected in the EI data system, parent survey data and other methods for oversight, monitoring, quality assurance, utilization review and to report to the United States Department of Education, Office of Special Education Programs (OSEP) and other interested parties.

Certified EI providers shall comply with these Certification Standards throughout the period of certification. DHS will monitor and evaluate providers for compliance with Medicaid and State laws as well as these Standards and DHS regulations and policies pursuant to the management of Early Intervention. Providers are required to complete all fields and screens accurately and completely in the EI data system as outlined in Certification Standards "Quality Assurance and Monitoring Standards." For purposes of quality assurance reviews, certified and provisionally certified providers will provide access to appropriate personnel and written records by DHS and/or its agents at reasonable times.

2. At least once every three years from the original date of certification, DHS will complete a thorough, on-site review of currently certified providers in order to assure continued compliance with certification standards.

DHS reserves the right to apply a range of sanctions to providers that are out of compliance. These may include:

a) Suspension of new referrals.
b) Change of certification status to Provisional Certification.
c) Recoupment of funds when violations of Medicaid regulations, State law, or DHS policies, including these Certification Standards have taken place.
d) Suspension of certification, depending on severity of violation with transfer of infants and toddlers and their families to another EI provider
e) Referral to appropriate legal authorities.

3. Additionally, currently certified providers will receive a corrective action plan letter no later than December 2nd, 2005 indicating areas of noncompliance outlined in Indicator 9A. Providers must submit corrective actions plans to DHS by February 1st, 2006 detailing plans to come into compliance with SPP indicators no later than December 2nd, 2006. DHS will forward a copy of this letter to OSEP for review in the APR due February 2007.

Monitoring Priority:

Effective General Supervision Part C / General Supervision

Indicator:

10. Percent of signed written complaints with reports issued that were resolved within 60-day timeline or a timeline extended for exceptional circumstances with respect to a particular complaint.

(20 U.S.C. 1416(a)(3)(B) and 1442)

Measurement:

Percent = (1.1(b) + 1.1(c)) divided by (1.1) times 100.

Data Source: Data collected on Part C Attachment 1.

Overview of Issue/Description of System or Process:

Any individual or organization, including an individual organization from another state may file a complaint that any public agency or private service provider is violating a requirement of Part C of IDEA by filing a written complaint with DHS. The complaint must be written and signed and include a statement of the State, other public agency, or certified EI provider that is identified as violating a requirement of Part C rules and regulations. The complaint must also include the facts upon which the complaint is based.

The alleged violation must have occurred not more than one year before the date the complaint is received by DHS unless a longer period is reasonable because: (1) the alleged violation occurs for that child or other children; or (2) the individual filing the complaint is requesting reimbursement or corrective action for a violation that occurred not more than three years before the date on which the complaint is received.

After the complaint is filed, DHS will give the parent or other individual/agency the opportunity to provide information regarding the issues in the complaint. DHS will investigate and resolve the complaint, utilizing mediation and/or a due process hearing that includes a review of all relevant information and an independent on-site investigation if necessary.

Baseline Data:

0 + 0 / 0 x 100 = 0

Discussion of Baseline Data:

One (1) signed written complaint was submitted to the Department of Human Services on 7/19/05. The complaint was regarding "the lack of timeliness the referral had been given" and "the manner in which the initial evaluation was planned". The family sent a letter to the provider as well regarding her complaint, which was attached to the DHS complaint. The initial evaluation was scheduled for 13 days beyond the 45-day timeline, but was then cancelled by the family as the family felt the evaluation was not scheduled with the disciplines the family thought most appropriate. The Early Intervention provider sent a response letter to the family explaining why the evaluation team was chosen, the evaluation took place on the date scheduled, and the complaint was withdrawn.

Measurable and Rigorous Target(s):

2006 Target: 100%
2007 Target: 100%
2008 Target: 100%
2009 Target: 100%
2010 Target: 100%
2011 Target: 100%

Improvement Activities/Timelines/Resources

1. Revised Certification Standards require clearly articulated Principles of Ethical Care and Professional Conduct must be publicly posted at all Certified EI provider sites. Protocols will identify standards of ethical practice for all EI staff. The latter shall include, but will not be limited to, the following issues:

- Grievance policies and procedures
- Discipline Policies

Additionally, DHS certified EI providers are responsible for assuring procedural safeguards that meet the requirements of IDEA, Part C. The intent of procedural safeguards is to assure that: (1) parents are fully informed of all recommendations being advanced by EI staff, (2) that such recommendations and direct services cannot be initiated or changed without written parental consent; (3) that parents are allowed the opportunity to inspect and review records; and (4) that in those instances in which disagreement occurs between provider staff and parents regarding any procedural safeguard violation, an impartial mediation and hearing procedures will be available for resolving such issues.

DHS is responsible for establishing procedural safeguards and assuring effective implementation of safeguards by each provider involved in the provision of EI services.

2. Certified EI providers must assure and document that a copy of the *Family Rights and Responsibilities* booklet is provided to all families at intake. Service Coordinators must

review these rights and responsibilities and complaint procedures with each family involved in EI.

In response to the letter received from OSEP on October 4th, 2005 based on RI's submission of its Federal Fiscal Year 2003 Annual Performance Report (APR), the RI Department of Human Services has revised the prior written notice form and policy to assure compliance with 34 CFR 303.403(a) as of October 2005.

Monitoring Priority:

Effective General Supervision Part C / General Supervision

Indicator:

11. Percent of fully adjudicated due process hearing requests that were fully adjudicated within the applicable timeline.

(20 U.S.C. 1416(a)(3)(B) and 1442)

Measurement:

Percent = (3.2(a) + 3.2(b)) divided by (3.2) times 100.

Data Source: Data collected on Part C Attachment 1.

Overview of Issue/Description of System or Process:

A parent may request a due process hearing regarding Early Intervention's proposal or refusal to initiate or change the identification, evaluation, placement or provision of appropriate early intervention services by submitting a written request for a due process hearing.

The written request, submitted by the parent or the parent's attorney, must include the name and address of the child, name of the parent submitting the request, description of the facts related to the problem and proposed ways to resolve the problem, if known.

When a hearing is requested by the parent, DHS will inform the parent of the right to mediation and of any free or low cost legal services available to the parent. DHS will be responsible for assigning an impartial hearing officer. The hearing officer assigned must have knowledge about the provision of Part C and about the needs of and services available for eligible children and their families. The hearing officer will perform the following duties:

- Listen to the presentation of relevant viewpoints about the complaint, examine all information relevant to the issues, and seek to reach a timely resolution of the complaint.
- Provide a record of the proceedings, including a written decision.

The impartial person may not be an employee of any agency involved in the provision of early intervention services or care of the child or child's family. The impartial person may not have a personal or professional interest conflicting with his/her objectivity in the complaint resolution process. Parties involved in administrative hearings/due process proceedings have the right to:

- Be accompanied and advised by counsel and by individuals with special knowledge or training with respect to early intervention services for children eligible under Part C of IDEA.
- Present evidence and confront, cross-examine, and compel the attendance of witnesses.
- Prohibit the introduction of any evidence at the due process hearing that has not been disclosed to the parent at least five days before the hearing.
- Obtain written or electronic verbatim transcription of the proceeding and obtain written findings of fact and decisions.

Due process hearings are conducted at a time and place that is reasonably convenient to the parents. During the proceeding, the child will continue to receive appropriate early intervention services currently provided unless parent and public agency otherwise agree. If a complaint involves application for initial services, the child receives those services that are not in dispute.

Resolution of Procedural Safeguard Violation

DHS will issue a letter of findings within 60 days of receipt of the complaint. An extension of the timelines will be permitted only if exceptional circumstances exist with respect to a particular complaint.

The letter will address each allegation with findings of fact, reasons for final decisions, and instructions to the agency or individual to correct any violations found during the investigation. DHS staff will identify the corrective actions necessary to achieve compliance and offer technical assistance and negotiation. If the complaint involved the delivery of appropriate services and the agency/provider is found to have failed to provide appropriate services, DHS will identify how the agency/provider must remedy the violation, including as appropriate the awarding of monetary reimbursement or other corrective action appropriate to the needs of the child and the child's family, and appropriate future provision of services for all infants and toddlers with disabilities and their families.

Additionally, the procedural safeguard performance standard requires the EI provider to respond to incidences of procedural safeguard violations as outlined in Section 5.7 within one (1) week to DHS. Failure to assure all procedural safeguards to the satisfaction of DHS may result in provisional certification status and associated reimbursement schedule changes.

Baseline Data:

0 + 0/0 x100 = 0

Discussion of Baseline Data:

DHS received zero (0) Due Process Hearing Requests between July 1st, 2004 through June 30th, 2005.

Measurable and Rigorous Target(s):

2006 Target: 100% compliance
2007 Target: 100% compliance
2008 Target: 100% compliance
2009 Target: 100% compliance
2010 Target 100% compliance
2011 Target: 100% compliance

Improvement Activities/Timelines/Resources

See Indicator #10 "Improvement Activities/Timelines/Resources."

Monitoring Priority:

Effective General Supervision Part C / General Supervision

Indicator:

12. Percent of hearing requests that went to resolution sessions that were resolved through resolution session settlement agreements (applicable if Part B due process procedures are adopted).

(20 U.S.C. 1416(a)(3)(B) and 1442)

Measurement:

Percent = 3.1(a) divided by (3.1) times 100.

Data Source: Data collected on Part C Attachment 1.

Overview of Issue/Description of System or Process:

Part B due process procedures are not utilized by Rhode Island DHS.

Baseline Data:

N/A

Discussion of Baseline Data:

N/A

Measurable and Rigorous Target(s):

N/A

Improvement Activities/Timelines/Resources

N/A

Monitoring Priority:

Effective General Supervision Part C / General Supervision

Indicator:

13. Percent of mediations held that resulted in mediation agreements.

(20 U.S.C. 1416(a)(3)(B) and 1442)

Measurement:

Percent = (2.1(a)(i) + 2.1(b)(i)) divided by (2.1) times 100.

Data Source: Data collected on Part C Attachment 1

Overview of Issue/Description of System or Process:

DHS assures parents or other affected parties have a right to access mediation services in order to address disputes related to the identification, evaluation, or provision of appropriate early intervention services under Part C of IDEA. The Early Intervention mediation process is voluntary on the part of all parties. Mediation may not be used to deny or delay a parent's right to an administrative proceeding or State complaint, or to otherwise deny the parent's or other party's rights under Part C of IDEA. The mediation must be conducted by a qualified and impartial mediator trained in effective mediation techniques.

The DHS maintains a list of individuals who are qualified mediators and knowledgeable in laws and regulations relating to the provision of special education and related services, and coordinates the assignment of an appropriately qualified mediator. DHS will coordinate the assignment of an appropriately qualified mediator.

Each session in the mediation process must be scheduled in a timely manner and must be held in a location that is convenient to the parties to the dispute. The assigned mediator shall prepare a written mediation agreement, which identifies the agreement reached by the involved parties. Discussions that occur during the mediation process shall be confidential and may not be used as evidence in any subsequent administrative proceeding or civil proceeding. DHS shall bear the cost of the mediation meeting, except any legal representation that parents or other parties may choose to have present.

Baseline Data:

0 + 0/0 x100 = 0

Discussion of Baseline Data:

DHS received no requests for mediation between July 1st, 2004 through June 30th, 2005.

Measurable and Rigorous Target(s):

2006 Target: N/A
2007 Target: N/A
2008 Target: N/A
2009 Target: N/A
2010 Target: N/A
2011 Target: N/A

Improvement Activities/Timelines/Resources

See Indicator #10 "Improvement Activities/Timelines/Resources."

Monitoring Priority:

Effective General Supervision Part C / General Supervision

Indicator:

14. State reported data (618 and State Performance Plan and Annual Performance Report) are timely and accurate.

(20 U.S.C. 1416(a)(3)(B) and 1442)

Measurement:

State reported data, including 618 data, State performance plan, and annual performance reports, are:

a. Submitted on or before due dates (February 1 for child count, including race and ethnicity, settings and November 1 for exiting, personnel, dispute resolution); and
b. Accurate (describe mechanisms for ensuring accuracy).

Data Source: State selected data sources, including data from the State data system, as well as technical assistance and monitoring systems.

Overview of Issue/Description of System or Process:

The Lead Agency uses data to affect the performance, stability, and quality of EI services provided to infants and toddlers and their families. The EI data system is the main source of programmatic information and must be utilized effectively and efficiently by certified EI providers.

Standards regarding personally identifiable information management, as well as Medicaid and Commercial insurance billing is as follows:

1) Certified EI providers must utilize the most current version of the EI data system as prescribed by DHS.

2) The organization obtains, manages, and uses information to enhance and improve its performance. Information it maintains is timely, accurate, and easily accessible, and in an electronic format. Evidence exists that information gathered and maintained is used in decision-making for the organization.

2) The organization maintains a written plan for information management which includes: client record-keeping policies and procedures; confidentiality policies and procedures; and record security policies and procedures. The plan provides for the timely and accurate collection of data and sets forth a reporting schedule.

3) The organization shall ensure that its information management systems are protected from unauthorized outside access and shall meet all applicable HIPAA regulatory requirements.

4) The information management plan specifies standard forms and types of data collected for client referral, intake, evaluation/assessment, services, and discharge.

5) The information management plan has an incident reporting and client grievance-reporting component.

6) Information management processes are planned and designed to meet the organization's internal and external reporting and tracking needs, and are appropriate to its size and complexity. Mechanisms exist to share and disseminate information both internally and externally.

    a) The organization maintains signed releases for sharing of information.

    b) Where necessary, Memorandum of Agreement (MOA) exist.

    c) Reports are available on an appropriate schedule (weekly, bi-weekly, monthly, quarterly, etc.) for use by service providers, service coordinators, supervisors, managers, CEO, and the Governing Body for assessing client and organizational progress.

    d) Reports to authorities (state, federal, and other funding and regulatory entities) for review are submitted accurately, in the required formats and on a timely basis.

7) The organization has written policies and procedures regarding confidentiality, security, and integrity of information, and has mechanisms to safeguard records and information against loss, destruction and unauthorized access or disclosure.

    a) The organization has policies and procedures in place to safeguard administrative records, clinical records, and electronic records.

    b) Electronic records are backed up, transmitted data is encrypted and secure, and access is password protected.

8) Each child's information is accessible and reviewed in a consistent and timely manner, with enough information to support family needs, to justify services delivered, and to document a course of treatment and service outcomes.

Baseline Data:

A. Data has been submitted on or before February 1st for child count, including race and ethnicity, settings and November 1st for exiting, personnel and dispute resolution.

B. DHS assures that data submitted is accurate and complete.

Discussion of Baseline Data:

A certified EI provider must be able to demonstrate compliance with core State requirements as to organizational structure and process. These requirements pertain to areas such as incorporation, management of administrative and financial systems, human resource management, information management, quality assurance/performance measures and others. State requirements in these areas are consistent with the types of expectations or standards which would be set forth and surveyed by health care accrediting bodies and which are generally held to be critical to effective, consistent, high quality organizational performance and care provision

Measurable and Rigorous Target(s):

2006 Target: 100% timely and accurate
2007 Target: 100% timely and accurate
2008 Target: 100% timely and accurate
2009 Target: 100% timely and accurate
2010 Target 100% timely and accurate
2011 Target: 100% timely and accurate

Improvement Activities/Timelines/Resources

1. Each EI provider is required to have policies and procedures and demonstrable activities for quality review and improvement (e.g. formal Quality Assurance or Performance Improvement Plan). The organization ensures that information is collected and used to improve the overall quality of service and performance of the program. The Quality Assurance/Performance Improvement (QA/PI) program that the organization develops strives to: improve the systems related to the delivery of service to the infants and toddlers and their families; include the preferences of infants and toddlers and their families in the provision of services; and measure the process and outcomes of the program services. The QA/PI program is an ongoing process of planning, monitoring, evaluating, and improving the system in order to improve the outcomes of service provided to infants and toddlers and their families.

Standards regarding Quality Assurance/Performance Improvement are as follows:

1) The organization has a Quality Assurance/Performance Improvement (QA/PI) program that includes a written performance improvement plan with annual review of goals and objectives, data analysis, outcomes management, records

review and operational/systems improvement. Written records are maintained for PI program activities and made available to DHS upon request

2) The QA/PI program contains specific timetables for activities and measurable goals and objectives, which consider client concerns and input.

3) Effective data analysis is conducted that includes an assessment of client or organizational needs, identification of service gaps, and integration of that data into organizational decision-making processes.

2. DHS staff includes an EI data manager. Technical assistance is made available to certified EI providers through this staff member as well as various resource documents including an EIMIS Manual. Utilizing the EI data system for monthly monitoring will allow DHS to analyze this data consistently and identify trends including data collection issues. Technical assistance needed regarding data collection will be reviewed and provided as needed.

Report of Dispute Resolution Under Part C of the Individuals with Disabilities Education Act
Complaints, Mediations, Resolution Sessions, and Due Process Hearings

SECTION A: Signed, written complaints	
(1) Signed, written complaints total	1
(1.1) Complaints with reports issued	0
(a) Reports with findings	0
(b) Reports within timeline	0
(c) Reports within extended timelines	0
(1.2) Complaints withdrawn or dismissed	1
(1.3) Complaints pending	0
(a) Complaints pending a due process hearing	0

SECTION B: Mediation requests	
(2) Mediation requests total	0
(2.1) Mediations	
(a) Mediations related to due process	0
(i) Mediation agreements	0
(b) Mediations not related to due process	0
(i) Mediation agreements	0
(2.2) Mediations not held (including pending)	0

SECTION C: Hearing requests	
(3) Hearing requests total	0
(3.1) Resolution sessions	0
(a) Settlement agreements	0
(3.2) Hearings (fully adjudicated)	0
(a) Decisions within timeline **SELECT** timeline used {30 day/Part C 45 day/Part B 45 day}	0
(b) Decisions within extended timeline	0
(3.3) Resolved without a hearing	0